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What's New—A Panel Discussion

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California MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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What's New in Gastroenterology

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RECENT medical progress in gastroenterology provides an opportunity for a brief commentary on some important new contributions and for a revision or review of older concepts and methods.

As to the present status of therapeutic measures directed toward the cure or control of two diseases —peptic ulcer and chronic ulcerative colitis—it is proper to stress the fact that these diseases still present a challenge, both as to etiology and as to therapy. No cure exists, and general principles still obtain.

Enterogastrone, duodenal extract, and extract of pregnant mare's urine all represent a search for the physiological approach to ulcer therapy. A certain amount of unfortunate publicity has raised as yet unwarranted hopes as to the efficacy of treatment of ulcer by duodenal extract or enterogastrone. To date no convincing evidence has been obtained that duodenal extract is of any striking value in altering the course of peptic ulcer. The bulk of evidence available at present in regard to the use of enterogastrone in the prevention or cure of ulcer leaves little room for enthusiasm. Sandweiss and his group concluded, on the basis of enterogastrone therapy in 42 patients, that clinical results were very disappointing. Symptom-free intervals were short, and recurrences were frequent. These patients were treated for a relatively short period of time, but the experience of others with this product for as long as six months to a year and longer strongly suggests that recurrences are not prevented in a high percentage of cases. The country-wide survey that is being carried out by Ruffin will doubtless be a valuable contribution to this subject. It is to be added that the product is as yet not obtainable in pure form, is irritating and expensive, and cannot be given in doses comparable to those used in early animal experiments.

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Presented as part of the Panel Discussion of "What's New" before the General Meeting at the 78th Annual Session of the California Medical Association, Los Angeles, May 8-11, 1949.

The effect of enterogastrone on gastric secretion in normal human beings in doses up to 400 mgm. was negligible in modifying gastric secretion after histamine or Ewald test meals. The use of pregnancy urine extract is not entirely new and is suggested by previous work by Sandweiss and Necheles with urogastrone, a gastrosecretory depressant extracted from human urine. The extract of pregnant mare's urine was used by Page and Heffner on 26 patients with intractable duodenal or jejunal ulcers. This substance has a gastric secretory inhibitory effect in animals and was given as an oral preparation. All other forms of therapy were discontinued during the therapeutic trial over a period of 20 months. Twenty-three of the 26 patients who were properly classified as having intractable ulcers responded favorably during this period of time. All of the chronic jejunal ulcers became asymptomatic within three or four weeks. Obviously such results are encouraging if they can be repeated by other observers and can be shown to be of lasting value.

The use of resins and protein hydrolysates as antacids or buffer solutions requires some comment. It is probably fair to say that in most instances resins offer little or no advantage over other commonly employed preparations. There is no evidence that they have any particular virtue. A careful study on the use of casein hydrolysate by Lopusniak and Berk of Philadelphia demonstrated that casein hydrolysate mixture has a somewhat better buffer and neutralizing action in the stomach than milk or milk and cream but that this buffer action was not significant in the first portion of the duodenum. Furthermore, the use of casein hydrolysate mixture was followed by fairly pronounced secondary stimulation of acid gastric secretion. It would seem that this mixture, except for the very special purpose of providing added nitrogen in badly depleted patients, has little to recommend it over the more orthodox feeding mixtures.

Section of vagal nerves for control of duodenal or jejunal ulcer is still on trial. Reports in the litera-

ture range from enthusiasm to skepticism. Enough time has elapsed to warrant some conclusions, although it is still too early to attempt to make a final evaluation of this procedure. It is fair to say that when performed as a single operative procedure it can be followed by unpleasant symptoms of fullness, gastric stasis, diarrhea, etc., in an appreciable number of patients, although as a rule these symptoms do not persist. Ulcer recurrences following vagotomy alone may run as high as 11 to 12 per cent, a figure that is definitely higher than that of recurrences after subtotal gastrectomy. The combination of posterior gastroenterostomy and vagotomy has received considerable notice, but patients so treated have not been followed for a sufficient period of time to warrant definitive statements. It may be that this type of operation will present a valuable addition to the therapy of ulcer. Certainly it appears to have been a very effective measure in the control of intractable stomach ulcers. It is considered fair, however, to urge conservative skepticism until more time has elapsed. The author's feeling is that vagotomy provides a real addition to the therapeutic armamentarium but that its use probably applies to carefully selected cases and final results following its performance are still not completely known.

Radiation therapy in peptic ulcer has been completely reviewed by Ricketts, Palmer and their associates in Chicago within recent months. This form of treatment is not new, but their report is of interest, inasmuch as it represents observations on more than 800 cases followed during the years 1936 to 1947. The total amount of radiation varied between 1,100 and 2,500 r in divided doses directed toward the fundus of the stomach. Such therapy produced acute transitory inflammation of the gastric wall, with hyperemia, hemorrhage, edema, exudate, and degenerative changes in epithelial cells and lymph follicles. Atrophy of the gastric mucosa often ensued and was uniformly present in patients with prolonged postradiation anacidity. Such irradiation of the acid-secreting portions of the stomach frequently produced achlorhydria, which varied in duration from a few days to as long as eight years. There was a higher incidence of postradiation achlorhydria in patients with gastric ulcer than in those with duodenal or jejunal ulcer. If achlorhydria was produced, ulcer pain disappeared, and if the achlorhydria persisted, there was invariable healing of the ulcer.

The investigators are careful to point out that while roentgen irradiation of the stomach may produce a profound depression of gastric secretion, this depression persisted for variable lengths of time which could not be predicted, nor could the degree of depression be predicted. The effect on the course of the ulcer depended upon the degree and duration of the secretory depression. It is important to note that in those patients with prolonged achlorhydria, gastric atrophy ensued, and it is wise to ask the question whether such an end-result is favorable and whether it might not lay the basis for future difficulties from possible malignant degeneration. It is probable that radiation therapy of peptic ulcer should be employed only in carefully selected cases otherwise resistant to treatment. It should be carried out only by skilled radiologists and should be followed by careful observation. It may represent a proper therapeutic maneuver in certain difficult cases.

The treatment of ulcerative colitis has received constant attention in recent years, but little new has been added. Aureomycin and chloromycetin to date have been tried in small groups of patients, with variable results. It is highly probable that these drugs are an addition of slight importance to the existing measures for attempting to combat colonic infection in this disease. The author's experience with these two preparations has been extremely disappointing.

Experiments indicate that lysozyme production is greatly increased in the diseased colon, but to date no measures have been devised to adequately inhibit lysozyme production or to reduce its activity in removing protective surface mucus. Treatment of ulcerative colitis with extracts of intestinal mucosa has been attempted by Friedman and Haskell of Philadelphia on the theory that there is a deficiency of an intrinsic protective factor or factors normally present in the bowel mucosa. Oral therapy with extract of the small intestine of hogs was tried in a group of patients, with symptomatic improvement in many, as noted by a decrease in frequency of bowel movements and disappearance of gross blood from the stools. Sigmoidoscopic observations also showed decreased mucosal friability, but in patients with widespread disease only a few showed any benefit as evidenced by careful x-ray studies. It is stated that the disease in patients so treated had been refractory to other measures, but such a form of therapy must be followed over a long period of time in this chronic, recurrent malady before a proper evaluation can be made of its effectiveness. It is to be pointed out that one patient had a terrific allergic reaction from the hog mucosa.

A new approach to the treatment of ulcerative colitis is that carried out in a small group of patients by Dennis, Eddy and Westover of Minneapolis, who have reported results of transthoracic vagotomy in 22 patients. Fourteen of these patients showed improvement following this procedure, but the authors are careful to point out that it is an experimental approach and should be so considered until a prolonged follow-up has occurred. It is of interest that in general the good results occurred in patients who had had the disease for only a short time and had minimal bowel scarring.

A very recent report by McDermott, Knight, and Ruiz-Sanches on the use of chloramphenical (chloromycetin) in the treatment of typhoid fever confirms the suggestion of previous reports by Woodard, who used this preparation in Malaya to treat typhoid and typhus. McDermott and his associates report on the treatment of 51 patients with typhoid fever. Four received polymyxin-B, but the drug was rejected because of severe toxicity. Thirty-five patients received

aureomycin in doses of 6 to 12 gm. daily, with uneven and questionable responses. The remaining 13 patients were treated with chloramphenical. In 12 patients the temperature returned to normal in approximately three days, and these patients remained afebrile while being so treated. One of the 13 patients died from a complication while under therapy. It should be pointed out that this remarkable response to the antibiotic was essentially one of a drop in temperature. The drug apparently had no effect on complications of the disease, and studies indicate that it did not reduce the number of typhoid carriers. Nevertheless, if these findings are confirmed, it would seem that an important contribution has been made to the treatment of a hitherto resistant infectious disease.

As to certain recent reports concerning liver disease and its treatment, although the idea is in no sense new, the very careful studies by Kunkel and his associates in New York on the effect of rigid sodium restriction in patients with cirrhosis of the liver and ascites is important because of the completeness of the study. The intake of sodium chloride of less than 1.0 gm. per day in 13 patients with steadily accumulating ascites immediately stopped fluid formation in the abdomen in all but one of the patients, with resulting clinical improvement and an associated rise in serum albumin. When sodium restriction was stopped, ascites returned in all but two of the patients, indicating the necessity of many months of such therapy.

The report by Berger and his collaborators on the effect of an exchange resin (Liquonex CR W) on electrolyte balance and its use in edematous states is of interest in this connection. Oral feeding of this resin resulted in the excretion of 80 per cent of dietary sodium and 70 per cent of dietary potassium in the stool without salt restriction. In a patient with cirrhosis and ascites, the ascitic fluid disappeared in 22 days without the use of other diuretics.

To clarify the role of protein in the treatment of human liver disease, Eckhardt and co-workers studied the effect of protein starvation on the clinical course of the disease and on liver function tests and liver histochemistry. Patients were fed a diet adequate in calories but not sufficient to maintain nitrogen equilibrium. A negative nitrogen balance resulted, but there was manifest clinical improvement, a decrease in liver size, and improvement in laboratory tests. Biopsy studies revealed a diminution of liver cell protein and no alteration in fat content. Resumption of protein feeding in adequate amounts, in addition to an adequate caloric intake, showed progressive histochemical improvement in the liver tissue. It is thus apparent that essential dietotherapy of degenerative liver disease must depend upon an adequate caloric intake and an adequate supply of nitrogen if optimum improvement is to be obtained.

The use of testosterone, choline and methionine was studied by Gabuzda and his group in Boston, who showed that in liver disease, testosterone proprionate had a protein anabolic effect in these patients but that a positive nitrogen balance was most effectively achieved by adequate dietary protein. No appreciable nitrogen-sparing action could be attributed to choline and methionine in generous dosage.

Further evidence that intensive therapy in degenerative liver disease promotes a reversal of serious alterations in liver function is shown in the recent studies of Sterling and his group from Chicago. Electrophoretic studies of serum protein in patients with cirrhosis were followed during intensive therapy. Serious alterations in the level of serum albumin, gamma globulin and and beta globulin fractions were gradually but steadily returned to normal levels in patients who were successfully treated, indicating that these evidences of altered function were not irreversible in many instances.

The use of human albumin has recently been studied by Post and Rose of New York, who administered this substance intravenously to 16 patients critically ill with decompensated cirrhosis for a period of about three months. Sufficient albumin was given to maintain normal serum albumin levels. Careful dietary measures were carried out at the same time, a fact which may well have contributed to the favorable results that were obtained. The authors noted striking improvement in 13 patients. Seven patients who showed pronounced diuresis were comatose when albumin therapy was begun. Rose and Post, unlike some other investigators, feel that intravenous albumin has a definite place in the treatment of decompensated cirrhosis of the liver. The author's observations in similar cases lead to the belief that this is an entirely correct assumption, although the results from intensive albumin therapy are not predictable in advance.

The use of fat in intravenous nutrition has promise of very great clinical importance. Two groups of investigators have recently presented evidence that specially prepared fat emulsions may eventually be available for intravenous therapy, a need that has long been felt. Stare and his group in Boston have amplified previous reports on the use of intravenous fat emulsions in rats and dogs by a very recent statement that within the past year, fat emulsions have been given successfully to human beings, furnishing as much as 1,000 to 1,500 calories by vein daily. Stare states that fat emulsions can be prepared which can be given intravenously without reaction and which contribute appreciably to caloric intake, without requiring large fluid volumes or prolonged infusion times. Studies by Chaikoff, Enteman and Dauben recently reported from the University of California similarly justify the conclusion that emulsified fat introduced directly into the blood stream is available for caloric purposes. These investigators showed that about 50 per cent of tagged injected fatty acids were recovered in the liver and had been incorporated into phospholipids at the end of 24 hours. Further elaboration of this idea should be of inestimable value in providing a means for the rapid control of serious malnutrition provided emulsions can be prepared which can be given without the danger of serious reactions or fat em-

bolism. At present, important studies are being carried out in relation to this particular problem by several other important investigative groups.

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QUESTIONS AND ANSWERS

DR. CHESTER JONES: The first question: "What about the cabbage juice diet for peptic ulcer recently reported upon from Stanford University?"

The proper answer would be—I don't know. It seems to me that the only attitude one can take is that this is an approach to the problem which has not been fully explored, and it is not known exactly what would be the answer. However, it is fair to say the cabbage juice is a glycogen and can cause goiter. Therefore, any such mechanism, if indulged in any length of time, should be watched with a good deal of interest, and also suspicion.

Question: "How do you treat uncomplicated duodenal ulcer? How strict a diet, and what medication?"

As time is limited, I will simply say I think the general principle that we all agree to, as far as medical treatment of uncomplicated duodenal ulcer, is about as follows: It is in two parts, first, treating of the ulcer, and then an attempt in between remissions, to either lengthen the interval of remission, or to prevent it completely. In most cases, physicians are not successful in completely preventing all remissions. In the acute phase, the indicated advice is frequent small meals of simple food. Time is a common denominator of all dietary measures. All one has to do is look at the details of the region to know that the actual food that is used, by and large, is not so important as the fact it is given frequently, on time, and in small amounts.

If the ulcer is very acute and very difficult to control, it means feedings during the night, as well as during the day; or, if one desires—and as a rule I don't—one can put the patient on nasal drip of continuous milk feeding, or provide continuous suction during the night to take away the night secretion. Those are measures that are usually not needed. A simple trick sometimes is to wake the patient up about 1 o'clock in the morning and have a feeding at that time.

How strict a diet? Very strict during the acute phase of several weeks. In between, I think any simple, well-cooked tender food eaten on time, at frequent intervals, five or six feedings a day, should be the proper dietary control for an ambulatory patient whose ulcer is not active at that particular moment.

I think there has been too much attention paid to the very minute details of diet, to the exclusion of a lot of other factors. Anything that contributes to peace of mind and avoidance of physical fatigue is obviously important. It requires knowing the person, and it takes more than a four-minute interview to accomplish that. It takes time.

As to the use of drugs: There is no specific drug that cures ulcer; no specific drug that gives you absolute assurance of the control of the ulcer problem. There are three approaches in the main, however. One is the anti-acid, and I think probably at present in most instances the aluminum gel compounds are good. The thing to do is to avoid that which causes constipation and bowel difficulty in the individual.

The second approach is that of desedation, I think, and very frequently during the acute phase of ulcer, desedation with barbiturates is helpful at times in combination with the use of atropine or its derivatives in order to produce a block on the end of the parasympathetic nerve ending of the stomach.

There is no substitute known among the new drugs to replace belladonna and atropine. The new drugs have proved ineffective in most instances. Furthermore, they are more expensive, and therefore, as a rule, have little to recommend them.

Belladonna is probably as good as any of the antispasmodics, only if given in adequate dosages. At times this does produce side effects, however, to preclude its use. During acute phases of ulcer, parenteral administration of atropine and sodium luminal by the clock, at eight-hour intervals for two or three days, often will get the situation under control. No medication in between recurrences absolutely prevents recurrences. The use of anti-acids certainly does not prevent recurrences.

Question: "Would you say something more about vagotomy, particularly in association with gastroenterostomy to obviate stasis in the stomach?"

I would like to say this: In trying to evaluate the original procedure, it was, I think, very much wiser to do vagotomy only in order to see what vagotomy produced. Simple vagotomy was done on a good many patients who had a certain amount of unrecognized or barely recognized pyloric obstruction. In those cases the operation was a complete failure. If you are going to use vagotomy alone, it is important to make sure there is no real partial obstruction near the pylorus, no matter how little it is. To obviate this, gastroenterostomy has been of real value.

In the intractable case that has been carried for a long time, this approach may be a really valuable one. But I'm sure that we haven't followed these cases long enough as yet. Grimson, who has done a good many at Duke, hasn't followed his cases long enough to be able to say that the recurrence rate is satisfactory. It seems to me that vagotomy should be watched closely, and that the number of cases in which the operation is done should not be increased until we know what a little bit longer observation will tell us. After all, it took us a good many years to find out the end result of gastrostomy, and it has taken us a good many years to find out what the end result of subtotal gastrectomy is. It seems the subtotal gastrectomy is still the method of choice.

Question: "How is it possible to treat a patient with cirrhosis and ascites with a high caloric, high protein diet, and yet keep the sodium intake low enough to prevent recurrence of ascites or edema?"

It simply takes the help of a well-trained dietitian to know how to estimate sodium in foods, and one who is capable of giving the patient some variety. It can be done. It requires care of the patient, and a certain amount of time. It isn't easy, but with good dietary advice one can get the information for the planning of such a diet.

Question: "Do you recommend nutritional supplements of B complex for chronic hepatic insufficiency?"

No. Although on the basis of all the facts that are in I'm not convinced that these are unnecessary, I do know that when one stresses supplements, almost always the patient turns to the supplements because they're easy to take in an adequate diet. One cannot get along on a fairly adequate diet and the use of supplements. The diet has got to come first. The emphasis has got to be placed there, and it has got to be continuous.

Furthermore, we have shown by careful studies on a group of patients using serol liver, that we can apparently get situations in which actually as good results are obtained by diet and rest alone. Rest is important. It cuts down the body requirement. It is just as good as when we added supplements and/or vitamins.

A really adequate diet which contains, I think in these cases, about 2 grams of protein and probably between 40 and 50 calories per kilogram of body weight contains all of the vitamins in that diet. It also contains perfectly adequate amounts of methionine and choline. Additions of

methionine and choline probably do not add enough to warrant their use. That is a personal opinion. I can't prove that last statement entirely, but I strongly suspect it is true on the basis of observations.

On the question of the needle biopsy—Dr. Womack brought out the points this morning, but I think it's only fair to state that some of us have done many hundreds of needle biopsies. If done by somebody who is trained to do it carefully, so the risk of the procedure, which is real but not large—it is a fraction of 1 per cent—is minimized, this method can give adequate information. Cecil Watts in Minneapolis any number of times has taken needle biopsies of the liver. About 3 centimeters in diameter, they show a good deal of the structure. It is always open to question, but in a diffuse disease, such as the condition we call cirrhosis of the liver, I'm sure it can be done.

The practical use of this measure is very valuable for study of the physiological condition. As far as the practical aspect in individual cases is concerned, there are only a few cases out of a large number in which one does do an accurate diagnosis. As Dr. Womack said yesterday, there are certain cases—for example, of painless jaundice—in which exact diagnosis is not possible. Every once in a while, it's important to know whether you're dealing with hepatitis or stasis in the bowel. There are various diseases that involve the liver which are not absolutely identifiable by ordinary laboratory tests, and frequently they can be elucidated by a good liver biopsy.

Question: "Repeat the name of the diuretic for diverting sodium in the gastrointestinal tract."

Liquonex. It is a trade name. It has just been reported in some work reported the first of last week at Atlantic City.

What's New in Orthopedics

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IN the enlargement of the field of orthopedic surgery, rapidly encompassing as it has much that was considered in the province of general surgery, the pace of developments has become greatly accelerated. Under "What's New," consideration should be given to recent research investigations, especially those of physiochemical nature, and to the more practical observations along clinicopathological lines, including changing ideas in teaching orthopedic surgery and the treatment of fractures.

It is evident that penicillin therapy has taken or may take the treatment of acute hematogenous or traumatic osteomyelitis out of the hands of the surgeon and put it into the hands of the internist or pediatrician, and at the same time has completely altered the prognosis. Dosages of 100,000 or more units are being given every two hours in proven or even suspected cases. This may be dangerous propaganda to spread amongst physicians who have never made an intimate study of bone infections, especially those resulting from injury, for the practitioner who is not specially trained may be inclined to handle them without the necessary meticulous debridement, careful hemostasis and traction, with or without splinting, when fracture is present. He who depends solely on the hypodermic injection will get into difficulties.

The author agrees with Lederle[5] that in open fracture the extension of thrombosis in adjacent blood vessels and the loss of vitality in infected bone with necrosis and separations are accompanied by a walling-off process in the local area which inhibits the access of penicillin-laden serum to the infected bone, thus nullifying the effect of the antibiotic. Judicious surgical treatment at the proper time might reverse this process.

Prolonged use of the antibiotics, started early in the attack of bone infection before destruction (death) of any large areas occurs, may cause the walled-off infected bone finally to become sterilized. Several weeks of administration may lead to aseptic instead of septic necrosis of the bone and avoid the formation of a gross involucrum or massive sequestrum. This bone then, under protection of proper splinting and freedom from intensive trauma, becomes replaced by new bone laid down within the old necrotic bone, thus saving bony contour and hopefully leaving growing areas in the epiphyses active. The use of antibiotics (penicillin) is now accepted in an earlier attempt at bone transplantation in areas previously septic, as after open infected fracture. Three to 8 million units are given over quite a long period of time and a surgical approach is sought to the nonunion remote from the old infected scar. This may be attempted within a few weeks after closure of the primary infected wound or the healing of defects left by chronic osteomyelitis.

In the field of physiochemistry, orthopedic surgery has been forced to consider the latest advances concerning blood coagulation and thrombosis, which are frequent bugbears after orthopedic operation and necessary long immobilization. Felder[3] advises the use of 500 mg. doses of Pitkin's menstruum with a small amount of a vasoconstrictor hypodermically, in divided doses in each thigh, as a practical method of lowering prothrombin time and raising clotting time, thus side-stepping thrombosis and embolism. This holds the clotting time elevated two or three times above normal for 48 hours. Dicumarol, if used, can only be given orally, as it is insoluble except in strong alkaline solution. Its use must be accompanied by careful prothrombin determination, as its action is delayed. The author does not use it preoperatively. On the first postoperative day, 300 mg. is given, 200 mg. on the second day and 100 mg. on the third day, trailing off to 50 mg. doses as the prothrombin determination may indicate in the face of a real thrombosis. In his work Felder found that thrombophlebitis developed in 6.6 per cent of patients operated upon for fracture of the hip. Loewe and Hirsch[6] believe that the incidence of secondary embolism was reduced from 30 per cent to 2.17 per cent and consider Homan's sign a valuable clinical adjunct.

Daily prothrombin determination in postoperative patients, as advocated in 1948 by Sandrock and Mahoney,[10] because of their value in predicting thrombotic complications, has been reviewed this year by McClure and his associates. Sandrock noted a sudden rise in the prothrombin level on the third postoperative day in several patients who either developed clinical thrombosis subsequently or received prophylactic dicumarol. McClure observed 12 instances of thrombosis in 179 patients, but in only six of these was there a warning from the prothrombin activity. Furthermore, thrombosis did not develop in 64 patients with high prothrombin levels. Results of tests for fibrinogen B (described by Lyons of Australia) were not of prognostic importance.

It is possible that instances of overdosage with anticoagulants and excessive lowering of prothrombin time may be controlled by the use of protamine sulfate in accordance with Allen's experiments on dogs at the University of Chicago. These points may aid in the reduction of postoperative thrombophlebitis and phlebothrombosis, especially in elderly people, and so lower further the mortality rate of

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prolonged traction or necessary operations on them.[10]

Freyberg and Levy[4] in an analysis of complications in patients with fractures of the hip found that preexisting diabetes, arteriosclerosis or hypertension did not compound the hazards to patients, although these diseases would have complicated any superimposed infection or vascular accident. They found pulmonary infarction in four patients with two deaths out of 29 patients who had complications in ten years. Allbright advises prophylactic use of estrogen or androgen against the osteoporosis in older women if long bed rest is contemplated. In these patients the porosis is not considered to be a disturbance of calcium and phosphorus metabolism, but as due to insufficient production of osteoid tissue.

The role of alkaline phosphates in osteogenesis has also come into prominence.[7, 8] It seems to be established that the enzyme alkaline phosphatase is concerned more with the formation of fibrocollagenous framework or matrix of the bone than the impregnation of this framework with calcific salts. Consequently, further research into the protein matrix of bone and other factors in the precipitation and fixation of bone salts is suggested to the bright young investigators of the Pacific coast.

In the clinicopathological field, attention must be directed to the reports of H. A. Thomas Fairbank of London entitled "An Atlas of General Affections of the Skeleton" printed in the recent British numbers of the *Journal of Bone and Joint Surgery*. These are well ordered and studied observations of a matured mind worthy of attention for "What's New in Orthopedics" and a stimulus for individual record-keeping through life by any surgeon.

Excision of the patella after various kinds of fractures is still a moot question, answered in part by Scott's[11] resume of 196 instances of fracture followed by 101 complete excisions and 33 partial excisions, a much higher percentage than anyone has hitherto reported. This is a very live subject and Scott's report was published only after the editorial board of the journal in which it was printed had subjected it to close scrutiny and severe criticism, and then on the basis that it was a provocative contribution. Undoubtedly there does follow considerable disability after many instances of complete excisions. Radical excision of joint malacia, however, either locally or by patellectomy, has been accepted as orthodox.

Additional new points concern reports on the treatment of poliomyelitis and fractures of the neck of the femur. In Steindler's[12] masterly remarks on the former, it is stated that the disease is not limited to the anterior horn cell although that is where the parenchymatous lesions are found, while elsewhere the lesions are glial or interstitial in character. Some of the lesions in the anterior horn cell also are reversible, unless the cell is destroyed. In that event the condition must be considered final. Therefore the principles learned from basic science laid down by Lovett 40 years ago make us cling to the use of rest and avoidance of stretch reflexes of the affected muscle or contraction of the antagonist. Along with this, immobilization of the paralyzed muscle is reduced to a minimum and weight bearing is allowed as early as possible. Prolonged recumbency is permitted only when spinal asymmetry threatens. Active movement in the form of a rational and purposeful program of muscle reeducation is advocated.

Fracture of the neck of the femur with sequences of aseptic necrosis of the head, arthritis of the hip and delayed unions is a subject of continuing study.[1, 13] Delayed weight bearing has finally become an acknowledged necessity if there is the slightest suspicion of aseptic necrosis of the head. Phemister[9] believes that drilling of the necrotic head with the insertion of transplanted bone pegs may prevent collapse and hasten the replacement of dead bone by new. Many patients thus treated must be studied to determine the final value of this suggestion.[1]

Changes in fracture nomenclature are under way. Committees have been appointed by several of the national surgical and orthopedic bodies to consider these first and finally to meet in joint sessions for adoption of more or less standard terms.[2] At its meeting in Boston, January 1949, the Committee on Fractures and Other Traumas of the American College of Surgeons voted unanimously to drop the meaningless terms "simple" and "compound" fracture and to use henceforth in all records and speech the descriptive terms "open" and "closed" fracture. This initial step in the program is worthy of consideration, as it will be extended to all printed matter.

Finally, new steps are being taken to revise the teaching of the subject of fractures. In the meeting of the committee just referred to Dr. Gallie of Toronto read a formal paper covering a subcommittee report on teaching in this important division of surgery, reviewing older methods, and calling attention to the lack of thorough preparation in anatomy, physiology and pathology as these subjects bear particularly on orthopedic surgery, under present systems of teaching. There has recently been a shift of the responsibility for this teaching from the surgical to the orthopedic faculty subdivisions, with resulting chaotic upset in the methods of instruction. The author discussed Dr. Gallie's paper, stressing the lack of coordination in the teaching of roentgenology and pathology and the overemphasis placed on operative treatment of long bone fractures in order to obtain a nice-appearing roentgenological film with little or no regard for the equally important functional and economic result. It appears now that very little undergraduate teaching on the subject of fractures can properly be given in the crowded medical curriculum, and that little only to senior medical students who may have a small amount of clinical experience and judgment. Soon all teaching on this subject will become graduate in type. If left in orthopedic hands, the teaching during the next 25 years will fall on the shoulders of men now holding residencies or fellowships in orthopedic surgery. And these men may not be fully prepared

to teach the subject, in that they have not lived through the changes in treatment brought out in the last 30 years and may not be well enough grounded in the history of the development of treatment. This may not deter them from advancing, however, if they have enough preparation in pathology, backed by practical experience in the handling of large series of cases. Orthopedic teachers cannot be made overnight nor after a few months' experience in military service. They must have thorough grounding in pathology plus a background of experience which cannot be obtained from books.

Special training of nurses and certification for orthopedic nursing is now practiced in several locations. It should spread everywhere in the United States.

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QUESTIONS AND ANSWERS

DR. SPEED: "Do you think pediatricians could keep poliomyelitis patients out of the orthopedic-health department wards, iron lungs, and short coffins, if they would control the congestive inflammation in the anterior horns and work by early counter-irritation along the nape of the neck and skin of the spine in the early stages?"

My answer would be divided into two parts. The pediatrician must conform to the state law requirements covering the disposition of poliomyelitic cases, in addition to whatever local health measures may be added to the state law by local ordinance.

I cannot see that the application of skin counter-irritation would affect in the slightest way the destructive process in the anterior horn cells, any more than a plaster on the abdominal wall would have any effect on the progressive pathologic changes in an acute attack of appendicitis. Such ideas as this have been dead and buried for 100 years.

What's New in Aureomycin and Other Antibiotics

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ANTIBIOTICS, or, more properly, chemotherapeutics, have developed with great rapidity in the few years of their existence. For each anti-infective agent which has received clinical trial and may be deemed worthy of discussion in a brief review of this sort, hundreds have been tried and discarded as lacking in certain desirable qualities. Many others are at present in various stages of development, and newer and more potent drugs will surely appear.

In spite of the availability of chemotherapeutic drugs active against most bacteria and rickettsiae and several viruses, exact etiological diagnosis has become increasingly important. While keeping in mind the treatment of the sick individual as a whole, the physician must clearly realize that he is treating an infection due to a specific pathogenic microorganism and not merely a pathologic process. Thus the best treatment of pneumonia due to pneumococci differs from that of pneumonia due to M. tuberculosis or psittacosis virus. Likewise pyelonephritis due to Staphylococcus aureus must be treated quite differently from that due to A. aerogenes. Assiduous search for the etiological agent must be paramount in the proper management of any infectious process.

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Presented as part of the Panel Discussion of "What's New" before the General Meeting at the 78th Annual Session of the California Medical Association, Los Angeles, May 8-11, 1949.

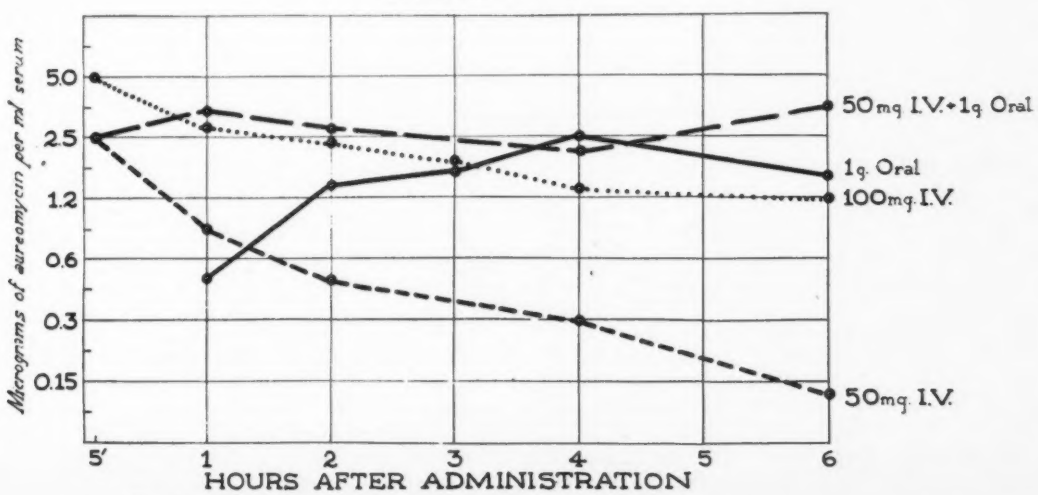
AUREOMYCIN

Aureomycin[14] is derived from *Streptomyces aureofaciens*, so-called because of its golden-yellow color. At present available commercially is the hydrochloride salt for oral use. The same purified salt will undoubtedly soon be introduced generally for intravenous administration. In addition, an ophthalmic ointment can be obtained for topical use.

Clinical Pharmacology. Aureomycin is absorbed rather slowly from the gastrointestinal tract. Although measurable amounts are detected in the serum after one hour, peak absorption is usually reached in two to six hours. Measurable blood levels may persist for eight to 12 hours after a single oral dose of 1 gm.[4] If oral administration of 1 gm. doses is continued at four- to six-hour intervals, gradual accumulation of aureomycin in the body occurs and serum concentrations in excess of 10 micrograms per milliliter of serum may be found after several days (Table 1).

Following the intravenous administration of 100 mg. an immediate peak serum concentration, usually in excess of that following the initial oral dose of 1 gm. is attained, followed by a gradual decline over a period of six to eight hours.[5] If oral and intravenous routes of administration are combined, immediate high serum levels are achieved and main-

TABLE I



Graph illustrating average serum concentrations of aureomycin following various intravenous and oral doses.

tained. The optimum serum concentrations of aureomycin for the treatment of various infections is not known.

Intramuscular administration of aureomycin is both painful and inefficient, since only minimal serum levels are observed.[4] Aerosolization is followed in some instances by systemic absorption.[5]

Aureomycin appears in most body fluids,[5] although usually after a delay of many hours. Measurable concentrations may be detectable in the pleural fluid, joint fluid, and cerebrospinal fluid after more than 24 hours of administration. Aureomycin appears quickly in the bile and urine. It has been detected in gastric contents eight hours after an oral dose.

Aureomycin is excreted slowly and irregularly in the urine. Urine concentrations in excess of 1 mg. per cc. may be observed occasionally. Urinary excretion may continue for 24 hours following a single intravenous dose of 100 mg. of the drug.[5]

Anti-Infective Spectrum. Aureomycin is active *in vitro* against a wide variety of Gram-positive and Gram-negative bacteria[5] as illustrated in Table 2, as well as L. icterohemorrhagica and Borrelia recurrentis.[21] In addition, *in vivo* activity has been demonstrated against the rickettsiae of the typhus, Rocky Mountain spotted fever, scrub typhus, and Q fever groups, as well as the viruses of psittacosis, lymphopathia venereum,[49, 2] and primary atypical pneumonia.[16] This activity has been confirmed in almost all instances by successful clinical trial.*

Toxicity. Aureomycin has been demonstrated to have little toxicity for animals. In man the only significant toxic effect has been the occurrence of nausea with or without vomiting in over half the patients receiving 1 gm. doses every four or six hours.[6] This has been avoided, whenever necessary, by resorting to intravenous administration. The nausea may subside spontaneously in spite of continued therapy, or may be partly alleviated by the use of aluminum hydroxide gels and by the presence of food in the stomach before ingestion of the drug.

Dosage. Exact dosage requirements in various infections are not established. One gram every six hours by mouth appears adequate in most infections due to susceptible agents. One-half this dosage will probably prove sufficient in primary atypical pneumonia and urinary tract infections due to highly susceptible bacteria. In severe infections or infections due to relatively resistant pathogens, supplemental intravenous doses of 100 mg. may be given simultaneously with the first few oral doses. If oral administration must be avoided because of nausea or for other reasons, 100 mg. may be administered intravenously every six to eight hours. A convenient plan includes three intravenous doses during the day, supplemented by one oral dose at night.

Results of Clinical Trial. Aureomycin has been used in a wide variety of infectious diseases, and preliminary evaluation of it may now be made. Comparison with penicillin, streptomycin, and chloromycetin must await carefully controlled studies.

TABLE 2.—*Response to Aureomycin.*

HIGHLY SENSITIVE ORGANISMS (Most strains less than 0.1 micrograms per ml.):
Staphylococcus aureus
Beta hemolytic streptococcus
Alpha hemolytic streptococcus
Streptococcus fecalis
Diplococcus pneumoniae
Corynebacterium diphtheriae
MODERATELY SENSITIVE ORGANISMS (Most strains less than 1.0 micrograms per ml.):
Escherichia coli
Aerobacter aerogenes
Eberthella typhosum
Salmonella (various types)
Neisseria meningitidis
Klebsiella pneumoniae
Hemophilus influenzae
Shigella paradysenteriae
RESISTANT ORGANISMS (All strains more than 3.5 micrograms per ml.):
Proteus vulgaris
Pseudomonas aeruginosa

In general, results of aureomycin therapy in typhoid fever and salmonella infections have been disappointing.[18, 29, 6, 19] Occasional patients respond in a dramatic fashion, but in the majority of patients only moderate suppressive effects or none at all are the rule. The stool culture may be temporarily rendered negative in the typhoid carrier state, but permanent beneficial effect is exceptional.

Aureomycin appears to be a highly effective agent in the treatment of acute brucellosis.[45, 29, 6, 19] Fever and bacteremia are usually quickly abolished, but relapses may occur in a significant number of patients. Small initial doses, as recommended by Spink,[45] should be used for the first three days of treatment to avoid Herxheimer-like reaction. Treatment must be carried out for ten days to two weeks. Experience in the treatment of chronic brucellosis is too limited to permit evaluation.

As is the case with other chemotherapeutic agents, aureomycin rarely produces permanent sterilization in infections of the urinary tract where severe anatomical abnormalities exist.[18, 33, 6] Most patients without obstruction of the urinary passages respond favorably to aureomycin therapy, with the exception of those in whom the infecting organism is a resistant strain of Ps. aeruginosa or Pr. vulgaris. In almost all cases, regardless of infecting organism or anatomical abnormality, marked suppression of the infection may be expected. Since the development of aureomycin resistance is uncommon, this temporary suppressive effect may be utilized to tide the patient over critical periods of disease in hopes of removing obstructive lesions at a later date.

Aureomycin exerts a beneficial effect on the course of pneumococcal pneumonia,[18, 36] and may be considered an alternative to penicillin in this disease. Results in other types of bacterial pneu-

*References: 6-9, 11-13, 18, 19, 25-27, 29, 35, 37, 38, 45, 53, 54.

monia and in lung abscess are as yet impossible to evaluate.

Acute gonorrheal urethritis responds favorably to aureomycin in most cases,[18] but the results appear definitely inferior to those of penicillin. Some types of bacterial meningitis may be amenable to aureomycin therapy,[29] although there is not yet sufficient evidence to permit evaluation.

Preliminary experience in pyogenic infections of the peritoneal cavity is promising[29, 6] as might be expected from an agent active against both Gram-positive and Gram-negative organisms. Limited trial in chancroid lesions likewise warrants further use of this agent. Pyodermia and erysipelas also appear to respond favorably.[29, 6]

Although aureomycin is highly active against streptococcus fecalis *in vitro*, results in the treatment of subacute bacterial endocarditis that is caused by penicillin-resistant strains of this organism have been disappointing. Although cures[29] have been reported, two patients who were treated relapsed after the termination of therapy, although the initial response had been satisfactory.[6]

In view of the experimental evidence of Heilman[21] that aureomycin is highly active against Leptospira icterohemorrhagica, the apparently favorable response in one patient[6] suggests that aureomycin may prove to be the treatment of choice in Weil's disease. Aureomycin has been widely used with success in the treatment of primary atypical pneumonia,[25, 37, 19, 29, 6, 36, 34] although relapses may occasionally be encountered after the discontinuance of therapy. Three patients suffering from psittacosis have responded favorably to treatment[6] with aureomycin after they had not improved under therapy with repository penicillin. Aureomycin appears to have no effect on the course of coccidioidal infection.[6] Preliminary reports suggest that aureomycin exerts a beneficial effect on lymphopathia venereum.[53]

Very favorable results with aureomycin have been reported in the treatment of typhus fever,[38] and of Rocky Mountain spotted fever.[12, 35] Although most patients suffering from Q fever seem to respond well to this drug, failures do occur.[27, 6]

Remaining to be evaluated is the role of aureomycin in the treatment of herpes simplex and herpes zoster. No beneficial effects have been noted in varicella, infectious mononucleosis, erythema multiforme, Hodgkin's disease, acute leukemia, or carcinoma.[6]

The principal activity of aureomycin is bacteriostatic rather than bactericidal. In this respect it is reminiscent of the sulfonamides. The immune mechanism of the host may be of great importance in the final eradication of infection.

PENICILLIN

Of particular interest as regards penicillin is the development of a repository penicillin-procaine complex with 2 per cent aluminum monostearate which will produce measurable blood levels as long as 120 hours after the injection of 300,000 units.[34] While this is a welcome simplification of the care of the patient receiving penicillin, caution in using this material in severely ill patients is advisable. Although serum levels are prolonged, peak concentrations are generally lower than those following administration of more rapidly absorbed preparations.

Of equal interest is the convincing evidence that beneficial clinical results may be obtained by infrequent intramuscular injections of aqueous solutions of crystalline penicillin.[1, 48] Although serum levels may not persist beyond three to seven hours after administration, significant amounts are present in the tissues for longer periods of time. Furthermore, organisms experimentally exposed for brief periods to concentrations of penicillin which would ultimately be lethal are intoxicated so that multiplication does not occur for several hours after their removal from contact with penicillin.[1] Thus such acute infections as pneumococcal pneumonia respond favorably to between 100,000 and 300,000 units administered every eight to 12 hours. In spite of the feasibility of these short-cuts in many cases, patients who are desperately ill should be treated with very large doses at frequent intervals so that maximal concentrations may diffuse into infected foci as soon as possible.

STREPTOMYCIN

The development of dihydrostreptomycin has accorded streptomycin a secondary role. The reduced derivative is as effective clinically as streptomycin in all types of infections and is considerably less toxic.[33, 22, 23] Eighth nerve toxicity is occasionally observed also with dihydrostreptomycin, but usually only when the drug is given in large doses and for long periods of time.

While the problem of the acquisition of resistance to streptomycin is far from solved, since organisms resistant to streptomycin are equally resistant to dihydrostreptomycin, certain promising developments have been noted. The simultaneous use of para-aminosalicylic[55] acid, and possibly promizole,[28] appears to inhibit the appearance of resistant strains of tubercle bacilli. Furthermore, recently developed substituted streptomycins have been found to be active *in vitro* against organisms resistant to streptomycin and dihydrostreptomycin. Gram-negative organisms resistant to streptomycin are usually quite susceptible to aureomycin, chloromycetin, or polymyxin.

CHLORAMPHENICOL (CHLOROMYCETIN)

Chloromycetin was originally derived from *Streptomyces venezuelae*[17] but has more recently been synthesized. Its anti-infective spectrum generally resembles that of aureomycin, although it exhibits considerably less activity against the Gram-positive cocci *in vitro*.[29] Chloromycetin is highly active against most Gram-negative organisms *in vitro* and against the rickettsiae *in vivo*.[39] In addition, activity has been demonstrated against the spirochetes, Bor-

relia recurrentis[44] and Treponema pallidum,[42] although activity against the latter is not great.

Chloromycetin is rapidly absorbed from the gastrointestinal tract and is excreted in the urine. No significant toxic effects have been noted. Initial doses of 50 mg. per kilogram of weight appear to be effective, and the dosage may be reduced after clinical improvement occurs.

Although clinical data on results of treatment with chloromycetin are scanty, good results have been reported in typhus fever,[40] scrub typhus,[41] typhoid fever,[26, 51] primary atypical pneumonia,[36] bacterial pneumonia,[36] gonorrhea,[42] brucellosis,[26, 52] and infections of the urinary tract due to Gram-negative organisms.[10] Chloromycetin appears to be definitely superior to aureomycin in the treatment of typhoid fever,[26] although relapses have been encountered in a significant number of cases.

POLYMYXIN

The polymyxins, of which there are several, are derived from *B. polymyxia*. Polymyxin A is also known as aerosporin. Polymyxins A, B, and D are cyclic polypeptides. All are extremely active against Gram-negative organisms with the notable exception of Pr. vulgaris and the Neisseriae.[46] Although polymyxin is considerably more bactericidal than streptomycin, aureomycin, and chloromycetin against Gram-negative bacteria,[3] it exerts a significant nephrotoxic effect in animals and human beings which will probably limit its use to desperate infections which are not susceptible to other chemotherapeutic agents.[29] The total daily dose of polymyxin ranges from 3 to 6 mg. per kilogram of weight divided into eight intramuscular injections. Beneficial effects have been observed clinically in pertussis,[47] bacteremias due to Ps. aeruginosa[33] and other bacilli, and urinary tract infections due to susceptible organisms.[29]

BACITRACIN

Bacitracin[24] is derived from *B. subtilis*. It is active against the Gram-positive cocci, the Neisseriae, the Clostridiae, C. diphtheriae, T. pallidum, and E. histolytica. It is not active against Gram-negative organisms. It is neither absorbed nor inactivated in the gastrointestinal tract, and thus depresses the Gram-positive cocci and Clostridiae when administered orally.[32] It is absorbed following intramuscular injection and is excreted slowly. Severe renal lesions may be observed in mice, rats, and man after intramuscular administration of this drug. Bacitracin manufactured by surface culture[43] appears to be less toxic than that made by deep-vat culture, so that side-effects may be eventually minimized.

Beneficial effects have been reported from the topical use of solutions and ointments containing 10 to 100 units of bacitracin per cc.[31] These infections included furuncles, ulcers, and chronic osteomyelitis. Favorable results were noted in about 70 per cent of "surgical" infections treated with bacitracin administered intramuscularly.[32] Because of its synergistic action with penicillin against T. pallida, it has been used experimentally in the treatment of syphilis,[15] but it is too early to evaluate the results.

DISCUSSION

While laboratory and clinical studies on these and other antibiotics have gone on at a bewildering pace, the approach has been principally the empirical one of trial and error. Lagging behind have been investigations into the mechanisms of action of chemotherapeutic agents. Although the principle of metabolic competition was first established in regard to the sulfonamides by Woods,[50] only fragmentary evidence is available to explain the action of penicillin and streptomycin. This subject has been ably reviewed by Goldstein.[20] A new era in chemotherapy will appear when drugs are designed specifically to interfere with the vital metabolic functions of the microorganism and, perhaps, the neoplastic cell.

Drs. Henry B. Bruyn, Jr., and Gordon Meiklejohn collaborated in the clinical and pharmacological studies on aureomycin.

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QUESTIONS AND ANSWERS

DR. BRAINERD: I have two questions on chronic brucellosis. One is: "What is the effect of aureomycin on chronic brucellosis?" The other is: "Why is chronic brucellosis more resistant to therapy than acute brucellosis?"

I don't know for certain what the effect of aureomycin is in chronic brucellosis. A number of cases have been treated but not followed a long enough period of time to tell. I think unquestionably, in many cases there is some effect. Whether it is lasting or not, I think is a very crucial question that time alone will settle.

Question: "Rectal administration of capsules of aureomycin has been suggested. Is this effective?"

We have not completed the studies on rectal administration. It would not be surprising that it is absorbed from the rectum. However, the pH of the solution is 2.5. This is exceedingly irritating. If is buffered, it may deteriorate rapidly. These are practical objections to rectal administration. However, they may be surmountable.

Question: "To what other antibiotic in addition to streptomycin is Friedlander's bacillus susceptible?"

It is susceptible to aureomycin, chloromycetin and polymyxin.

Question: "Have there been reports of anaphylactic reactions to penicillin?"

Yes, there have. They are exceedingly rare. Most reactions, however, are not acute or serious, but merely a nuisance, often resembling serum sickness.

Question: "Are there any antibiotics of value against coccidioidal infections?"

There is one antibiotic which is effective against mycotic organisms. It is an actidione which is still in the early experimental stage. It has been used some in coccidioidal infections with some suggestive beneficial results in dogs. Its toxic effects in man are not fully worked out. However, it is of considerable promise in mycotic infections in general.

Question: "Is it safe to give aureomycin at the patient's home?"

Yes, I would say it lends itself particularly to administration at home, since the only toxic effect of any consequence is nausea and vomiting, and this is rarely serious. It could be given by mouth, which is a great advantage.

Question: "Has aureomycin been used in the treatment of Reiter's disease, and if so, with what results?"

Finland reported one case of apparent Reiter's disease which he felt was benefited to some degree by aureomycin. I have treated one patient—I was not certain what he had was Reiter's disease—without any effect. There is some animal evidence which would suggest that there is some activity against the organism.

Question: Does aureomycin act by producing basodilatation?

I think that, by and large, the physiological effects of all the antibiotics are almost nil. Their activity is, of course, quite demonstrable in the test tube where there can be no physiological effect other than the action on the affecting organism. However, that does not minimize the importance of the immune mechanism of the body. In the final abolition of pathogens from the body, all chemotherapeutic agents are probably principally bacteriostatic rather than bactericidal, and the immune mechanism of the body is very important in the eradication of infection.

What's New in Gynecology

JAMES C. DOYLE, M.D., *Beverly Hills*

PROGRESS has been recorded recently in all phases of gynecology, diagnostic, therapeutic and surgical. The discoveries and subsequent application in chemotherapy and antibiotics have been of an inestimable value. Particularly has the management of acute and subacute pelvic gonorrheal infections been affected. Patients with such infections receive 100,000 units of penicillin intramuscularly every three hours for 24 hours; 50,000 units every three hours thereafter, as warranted. Not infrequently the author further prescribes a sulfonamide preparation (triple), 1 gm. three or four times a day, combined, of course, with the usual medical care.

Although it is too early to evaluate the results, the author has used streptomycin in the treatment of one patient with pelvic tuberculosis. Dihydrostreptomycin,[4, 9, 10] a newer and less toxic form, was given. The patient, a 17-year-old Negro girl with a past history of pleural effusions, was given 0.5 gm. twice daily for ten days prior to and for 20 days following operation. When bilateral tubo-ovarian masses (6 to 8 cm.) were removed along with the uterus totally, extensive peritoneal and visceral tuberculous implants were noted. Two gm. of dihydrostreptomycin in saline was left in the peritoneal cavity prior to closure. Convalescence has been afebrile and satisfactory to this time.

LYMPHOGRANULOMA VENEREUM

Of interest to the gynecologist is a new antibiotic, aureomycin, described first in July 1948.[2] Although published reports are few, preliminary studies by Greenblatt[7] and others indicate aureomycin to be highly effective against the lymphogranuloma venereum group of diseases — benign rectal stricture, buboes and proctitis. Further, *in vitro* studies seem to show bacteriostatic or bactericidal activity against a wide variety of Gram-positive and Gram-negative bacteria, as well as against penicillin-resistant and streptomycin-resistant organisms. Oral use is recommended with a suggested dosage of 25 to 100 mg. per kilogram of body weight daily, according to the severity and type of infection.

BARTHOLINIAN ABSCESS

The author has aspirated Bartholinian abscesses with an 18-gauge needle on the mucous membrane side, following application of an aqueous solution of zepherin to the skin. The purulent fluid is replaced by 300,000 units of penicillin in saline solution (8-10 cc.). In a small series, observed about six months, surgical intervention has been avoided. As infection not infrequently coexists elsewhere, 500,000 units of penicillin is also given. Goldberger[6] and Lapid reported equally successful results.

VAGINAL THERAPY

Occasionally before, and frequently after operations involving the vaginal canal, the author has given the patients allantomide cream (sulfanilamide 15 per cent, 5 per cent lactose, buffered to pH 4.5 with lactic acid and allantoin.) One-half the contents of an applicator is expressed through a tube into the vagina daily. It is felt that the acid pH stimulates healing, while the sulfanilamide decreases incidence of infection. As an office procedure, this is recommended following cautery of the cervix. Patients have noted a welcome freedom from odor while the cream is being used. Although the reports[19] have not been favorable, the author has had particularly gratifying results with this medication in treating vulvovaginal mycoses due to candida albicans, but results with it against trichomonas have not been as successful as those reported by Parks.[19] Discontinuance has rarely been necessary because of sulfa sensitivity.

SENILE VAGINITIS

The treatment of senile vaginitis has been considerably simplified by the development of an estrogenic cream called Premarin, suitable for vaginal injection. By this method the mucous membrane is coated with a cream, affording an almost immediate healing and soothing effect. It is superior to suppositories, and oral medication is not necessarily needed. The side-effects frequently noted with synthetic products have not occurred.

INTRACTABLE PRURITUS VULVAE

Pruritus vulvae, often as disconcerting to the physician as to the patient, frequently occurs. It has been variedly attributed to many causes. Hill[8] suggests that in 75 per cent of cases it is due to neurogenic or functional causes; in 15 per cent to lichen sclerosus et atrophicans, kraurosis with or without leukoplakia; and in the remaining 10 per cent is caused by diabetes, infections caused by trichomonas and fungi, and allergic reactions to drugs and food. Complete study may be necessary and consultations sought before a diagnosis is established. The treatment may be protracted and and ineffectual. The patients often go from physician to physician. Efforts are directed toward the elimination of known etiological factors, for example, trichomonas and

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monilia. Because of constitutional inadequacies in patients with the disease, it is imperative that the patient-physician relationship be particularly harmonious and understanding.

Many surgical and roentgenological methods have been tried repeatedly without success. The author has used a method decribed by Reich,[20] consisting of injection of a substance, Zylacain,* with benefit to 58 patients. Three patients were reinjected within six months, resulting, as far as the author knows, in permanent relief. In one case the method was a complete failure. Two and one-half cc. of Zylacain solution is injected across the mons pubis and 5 cc. under each labium major (in the fatty subcutaneous tissue) and across the posterior fourchette between the anus and vagina. The author has doubled these amounts with no unfavorable sequelae. The rationale of this method of treatment presumably lies in a temporary interruption of the nerve pathways.

SMEAR DIAGNOSIS OF CANCER

The diagnosis of cancer has been facilitated by a new technique originated by Papanicolaou,[16, 17, 18] continued by Shorr[23] and Traut. The clinical application was quickly foreseen with consequent rapid expansion. This work is based on the premise that cancer of the female generative tract sheds its cells early and these may be collected, stained and studied.

The chief value at this time would appear to be a screening method for a large portion of our population, supplementary to well established and proven diagnostic tests such as multiple biopsies and curettage. It is agreed that the smear test should be encouraged in the semi-yearly or yearly examinations. Hope for an increased rate of cures lies in detecting the preclinical phase of the disease, but the limitations of the procedure are growing increasingly clear and the abuses becoming apparent. For instance, hysterectomy is not justified on the basis of a positive smear. In the absence of a known lesion, time can be taken for a recheck of the smear, possibly by other cytologists; moreover, examination of tissue obtained by biopsy, conization and curettage should be confirmatory, before radical measures are instituted.

Finally, it should be stressed that this is only another diagnostic aid, not to supplant a complete history and visual and palpatory examinations of the pelvis. The most important facet is interpretation of the smears, wherein special training, with an infinite degree of patience, is essential.

CARCINOMA IN SITU

The management of intra-epithelial carcinoma of the cervix, a comparatively rare lesion, has been radically changed. Over half of the patients with this disease who were studied by Te Linde[25] and Galvin[5] had some type of irregular bleeding, more commonly post-coital spotting, but history of it was elicited only by pointed questioning. Otherwise the patients were asymptomatic.

During the last few years, a new approach to the diagnosis and management of this early malignant process has resulted from the work of Te Linde and Galvin. Their substantiated belief is that cancer of the cervix begins in the basal layer of the portio vaginalis and that slight changes in this layer may be the precursor of the intra-epithelial cancer. As most cervical cancers begin at the junction of the stratified squamous with the columnar epithelium, biopsies should include this junction. In this preclinical group the Papanicolaou smear would be particularly applicable.

A new treatment, recommended by Te Linde and Galvin, consists of total hysterectomy and removal of the parametrium for 2 cm. on either side of the cervix, plus a generous cuff of the vagina. They suggest preoperative placement of ureteral catheters and caution that great care is necessary to preserve the ureteral blood supply, as damage to it may cause fistulas. Some observers have questioned the wisdom of conserving an ovary as is sometimes done when this procedure is carried out in a young woman. A few more years will undoubtedly provide the answer. Among 67 patients operated upon between 1940 and 1948 there have been no recurrences to date and all are living.

This procedure is done only in the case of microscopic cancer. If the lesion can be seen by the naked eye, radiation is indicated.

The treatment of recognizable cancer of the cervix is by radiation; operation is restricted to a small percentage of young, good risk, thin patients, with limited metastases. Largely through the efforts of Meigs,[14] Taylor,[24] Morton,[15] Martzloff[13] and Carter,[1] a renewed interest in the radical Wertheim[26] treatment of carcinoma of the cervix has developed. Meigs' reasoning for radical operation is based on these points: One, that removal of the cervix eliminates the possibility of recurrence in it; two, that certain cervical cancers are radioresistant (adenocarcinoma-mucoid); three, that operation damages the bowel less than does radiation; four, that lymph node metastases are in some cases more likely to be cured by operation than by radiation. The operation is a formidable one which demands the ultimate in surgical skill.

STRESS INCONTINENCE

For urinary incontinence in the menopausal period, Salmon[21] and his co-workers reported favorably on vaginal suppositories containing stilbestrol. The same hormone was used by veterinarians to overcome incontinence in spayed dogs.

An entirely new development is Kegel's[12] treatment of urinary stress incontinence by exercises to strengthen and reeducate weak perivaginal and periurethral sphincter muscles. Studies with a "perineometer" convinced Kegel that congenital weakness of neuromuscular structures of the perineum was the causative factor in many cases. He found that

*2 per cent procaine, 5 per cent benzylalcohol in oil, prepared by Abbott Laboratories.

in 70 per cent of 200 women complaining of poor urinary control the condition was caused by muscular dysfunction of a degree not requiring operation for correction. "All [of the 70 per cent] responded to muscle reeducation in two to six weeks," he reported.

CULDOSCOPY

Visualization of the pelvic viscera through the posterior vaginal wall by means of an instrument is known as culdoscopy. According to Decker[3] indications for use are: In establishment of correct diagnosis when all other aids have been exhausted (as in possible ectopic pregnancy), in locating ruptured bleeding corpus luteum cysts or follicular cysts, in search for the cause of vaginal bleeding if results of conventional pelvic examination are vague or indefinite, in some sterility studies, in ruling out small ovarian tumors, cysts, pelvic endometriosis, or pelvic tuberculosis. Use of the instrument is contraindicated in the presence of such local abnormalities as abscess or inflammatory processes involving the culdesac, fixed retroposition of the uterus and acute infections of the vagina. It is also contraindicated for patients with systemic (i.e. decompensated) heart disease or for those who are so debilitated that the knee-chest position would be inadvisable. There have been no unfavorable sequelae to use of the instrument in experienced hands.

PREMENSTRUAL TENSION

Characteristically the symptoms of premenstrual tension simulate those of the menopause, the foremost being nervousness, irritability, tension, headache and depression. Of less frequent occurrences are hot flashes, vertigo and insomnia. Although some physicians give estrogenic substances for relief of the condition, this seems ill-advised in view of the concept that too much estrogen may already be present during this period. A suggested treatment is androgen, 80 to 100 mg. a month in divided doses, but any prolonged use of this substance should be discouraged. The author's recommendation is progesterone, 10 mg. tablet once or twice daily, and ammonium chloride, 0.5 gm. three times daily, for ten days prior to menses. Occasionally it is advisable to restrict intake of sodium chloride. Results with this medication have been exceedingly satisfactory.

BASAL TEMPERATURE

Helpful in ascertaining the time of ovulation is the rectal temperature, taken prior to arising daily and recorded graphically. A slight fluctuation is noted from the first day of menstruation to ovulation, but when ovulation takes place the temperature drops by ½ to 1 degree or more. The following day a rise of ½ to 1 degree occurs and that level is maintained until the beginning of menses. Should pregnancy ensue, the temperature remains elevated.

NEW SURGICAL RECOMMENDATIONS

In correcting post-hysterectomy prolapse of the vagina, Shaw's[22] method of utilizing the anterior rectus fascia as strips, threaded back and down following the course of the round ligaments, with fixation to the vagina, gives a satisfactory support. In a case of prolapse of the vaginal vault observed by the author, in addition to the Shaw procedure the sacro-uterine ligaments were approximated and fixed to the vault. After eight months, no recurrence is evident. For correction of prolapse of the cervix, the author has observed good result with vaginal trachelectomy.

Judd[11] has recommended intra-abdominal repair of moderate sized cystoceles when total hysterectomy is necessary. The pubocervical fascia is approximated to the sacro-uterine ligaments and the vaginal vault. This procedure is ideal in the presence of small cystoceles without incontinence, for otherwise the anterior plastic operation would have to be accomplished prior to the laparotomy.

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QUESTIONS AND ANSWERS

DR. DOYLE: There is a question about the Bartholinian abscess treatment: "How long after aspiration and penicillin treatment of these abscesses have you followed up these cases?"

These cases have been observed around six months. The cases now under observation at General Hospital have only been of recent issue. There have been one or two recurrences. It is possible that if patients in the acute stages were watched a few days longer, and reinjected with penicillin, operation could be avoided. It is not an entirely new procedure. It has been used also in pelvic abscesses, and other abscesses of the chest and elsewhere that had only to be reached with a needle.

What's New in Surgery

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MUCH of that which is new in surgery eventually will prove not to be true, and much of that which apparently is true will be found not to be new.

With the increase in knowledge that has come about during the past few years regarding homeostatic mechanisms in the body, the domain of surgery has been extended considerably insofar as the successful removal of viscera is concerned. The correction of obvious physiologic defections in the cardiovascular system, not by amputational methods but by anastomotic procedure, has been a brilliant achievement during recent years. This again is based upon intimate information concerning basic physiologic mechanisms. The same basic approach relating to the nervous system and the alimentary tract has been most fruitful in its product. All of these achievements, dramatic as the end results may be, are based upon sound and intimate understanding of functional mechanisms in the body.

This presentation will not attempt a review of the important operative achievements in surgery during the last year but will be limited to another phase of endeavor in which the surgeon may play an important role in the understanding of disease. The surgeon, like the practitioner in other fields of medicine, is fundamentally an applied biologist. He must understand those abnormalities which take place in the human body, for by so understanding them he often can develop methods by which these aberrations can be remedied. It is impossible for him to understand such abnormalities in structure and in function of the body unless he first has a clear conception of normal structure and of normal function, not only of the body as a whole but of its component tissues and their component cells.

This is no easy task to ask of anyone. Much of the normal is as yet not fully understood. It is the effort to appreciate as many mechanisms as possible that makes it encumbent upon surgeons to adopt those techniques and those principles that have been and are being developed by students of the fundamental sciences to which surgery is ancillary.

The surgeon is always a pathologist. Whether he is conscious of this fact or not makes no difference. Whether he wishes to utilize the usual methods of making a diagnosis such as inspection or palpation as used at the operating table or whether he has carried this to a more detailed correlation with microscopic studies also makes no difference. It is impossible for him to suggest with any degree of accuracy a therapeutic procedure at the operating table unless he has decided the nature of the condition confronting him. Pathology then becomes an essential element in surgery and not a thing apart. Pathology is not a discipline which the surgeon studies in order to pass his board examinations or in order to appear erudite. Pathology is the study of disease. It is an absolutely essential part of the surgeon's armamentarium that he study disease and that he understand its fundamental implications.

The surgical pathologist likes to think that he studies the tissues of the living, whereas the classical pathologist studies the tissues of the dead. He often forgets that there is but little difference between the study of the dead tissues of the living and the tissues of the dead. He often forgets that this method of study which he uses for a microscopic appraisal of a lesion carries with it many artefacts. Following its removal, the tissue is immersed in a fluid that precipitates most of its protein structure. Again, the fat is dissolved. This is followed by a procedure in which most of the water-soluble elements are removed. The thin section of tissue then is stained with various types of dyes that owe their action to physical and chemical affinities to various portions of the cellular architecture.

This is not to decry this method of study. It has given us much in times past by the very constancy of the artefact. It has afforded us the scaffolding upon which the classification and much of the present understanding of disease has been built. At times, however, it has resulted in much rigidity, insofar as classification is concerned, and we all have been guilty of becoming so bemused by semantics that sometimes the goal of true understanding of disease has been neglected.

Several years ago the author began a clinical study in which small amounts of liver tissue for microscopic study were removed from patients with liver disease of an unknown nature. Frequently confronted were patients who gave a history suggestive of hepatic damage. The outstanding complaints were jaundice of a painless type and either constant or intermittent weakness, and usually an enlargement of the liver. Clinical liver function tests would show evidence of liver damage or else the interpretation of them would be equivocal. It was found that in many of these patients biopsy of a small amount of liver tissue could be done without particular hazard. As a rule, procaine infiltration anesthesia was used and as much as possible of the upper right quadrant examined with the palpating finger. A small area of the liver was exposed to view, and a wedge of tissue removed for microscopic examination. With this procedure, it was possible to be certain that there would be no bleeding or leakage of bile after the biopsy. Furthermore, it was often possible immediately to determine the presence or absence of stone or of cancer in the liver or its vicinity. The microscopic examination of this tissue often was most revealing.

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By the use of suitable staining techniques, such diagnoses as primary tuberculosis of the liver, carbon tetrachloride poisoning, amyloid disease, primary parenchymal cancer, or cancer superimposed upon cirrhosis, were at times established. The largest group of patients, however, fell into an indiscriminate classification of so-called toxic hepatitis. Some of these lesions were acute, and others were associated with scar tissue and cirrhosis formation. In striving to elucidate further the exact mechanism concerned in the production of this type of liver damage, it was found impossible, with the staining techniques employed, to progress beyond such a vague classification.

Because of the fact that the function of a cell is the resultant action of its various enzyme systems, it became apparent that the classical microscopic techniques must be complemented by an appraisal of the functional state of as many of these enzyme systems as is possible.

Many techniques for this study were available, many more than have been utilized at the present writing.

The incubation of fresh tissue in a substrate containing a material which, when acted upon by certain enzymes, results in the deposition of stained material within the cytoplasm of the cell, is a method which has been in use in the study of normal cells for a considerable length of time. By this method it has been possible to determine the presence or absence of many of the vitamins. By the use of such a technique, it also has been possible more recently to determine the presence or absence of alkaline phosphatase, acid phosphatase, esterase, and lipase, as well as other of the enzymes. Both of these methods, to a large extent, are qualitative in type. But the problem in the study of the damaged liver cell was not only a qualitative one but also a quantitative one.

In order to study the tissue in a quantitative manner, various techniques of biochemical analysis as related to some of these enzyme systems, are being employed. This work is too recent to speak of statistically or authoritatively. It, however, has progressed far enough to allow encouragement of its continuation. The first study to be employed has been the determination of the amount of oxygen uptake in fresh hepatic tissue removed at operation by the use of the methods begun by Warburg. It was found that hepatic cell respiration, for instance, was interfered with considerably. In 15 successive patients with hepatic damage, either early or associated with cirrhosis, it was found that the oxygen uptake was diminished at least 50 per cent and yet the liver was able to carry on its over-all function adequately—adequately in the sense that the patient eventually showed considerable improvement.

It would seem that the more information of this type that is acquired, the more accurate can be the observation of the manifestations of disease; the greater the possibility for clear focus of attention on the site of tissue damage, the more likely that the cause can be ascertained and this particular type of damage thereby prevented. The author has no illusions as the difficulties involved. To a biochemist, these difficulties perhaps are far greater than envisaged by a surgeon. Yet this is a function in which the surgeon will play a great role in the future. He participates, because he excises the material for biopsy. It is one particular way in which surgery is adding to the new.

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QUESTIONS AND ANSWERS

DR. WOMACK: My questions centered around the comparison between the use of the needle in biopsy of the liver and the use of the incision in exposure. It's an old question. The internist, by custom, has been excluded from using the scalpel. He has had to use the needle, and it is the surgeon who has always used the knife.

Fundamentally, we're concerned with the study of tissue. If one can get an adequate amount of tissue with a needle, then well and good. And some have developed this technique to a very amazing degree.

As to the method of choice, several factors enter into decisions. Tissue removed by needle is sufficient only for microscopic examination, and the tissue is often distorted.

On the side of obtaining a biopsy with a scalpel, here is an example of why I prefer actual inspection of the liver: Too often, I've found that what I had interpreted in a clinical evaluation as primary liver damage was a silent stone in the common bile duct. When such a situation is found, one can go ahead and enlarge the exposure and do a definitive operation. Such diagnoses have been made after needle biopsy has revealed liver necrosis secondary to obstruction.

The Effect of Vitamin B_{12} on the Anemia and Combined System Disease of Addisonian Pernicious Anemia

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SUMMARY

The effect of the parenteral administration of vitamin B_{12} has been observed in eight patients with Addisonian pernicious anemia.

Vitamin B_{12} in initial doses of 50 micrograms or 25 micrograms induced satisfactory reticulocyte response and a return of erythrocyte count to within normal range in 60 days.

In only two of the patients were secondary reticulocyte responses induced on a second injection of vitamin B_{12}.

Concurrently with the hemopoietic response, the bone marrow changed from megaloblastic hyperplasia to normoblastic distribution.

The paresthesias associated with combined system disease as well as disturbances in position sense and locomotor function may be entirely relieved or greatly diminished following injections of vitamin B_{12}.

Maintenance injections of vitamin B_{12} may be from 30 to 50 micrograms at intervals of one month, the amount depending upon the individual case.

Vitamin B_{12} may be used without untoward symptoms in patients previously sensitive to liver extract.

IN 1926 it was demonstrated by Minot and Murphy[5] that whole raw liver was effective in the treatment of Addisonian pernicious anemia. Soon after this, a search was begun by investigators to determine the factor in liver responsible for its effects on the hematopoietic and neurologic systems. Cohn[3] in 1927 produced an extract of liver called "Fraction G" which became available for oral use. This was a water soluble material obtained from protein precipitation. The early preparations contained histamine-like substances which limited their parenteral use in patients because of their blood pressure reducing effect. In 1930 a more highly purified product was produced which was first called crude liver extract and contained one or two units per cc. of extract.[6] Within the past ten years, with the development of more highly refined techniques, such as salting-out processes, and reducing extracts to temperatures of an extremely low degree, a product of higher concentration has been produced containing 10 to 15 units per cc. of extract.[7]

The chemical formula of liver extract is not known. West and others, after many years of study, concluded that it was probably a polypeptide. Irrespective of this paucity of knowledge concerning its chemical structure, there is evidence suggestive of a close relationship between liver extract and the vitamin B complex. Wills,[14,15] Wintrobe,[16] and others have shown that in certain macrocytic anemias, large doses of yeast, a substance rich in vitamin B components, will induce a reticulocyte response followed by an increase in the number of erythrocytes in the circulating blood. Studies undertaken in our laboratory have shown comparable results. However, with the isolation and synthesis of each new member of the complex their ineffectiveness in the treatment of pernicious anemia have been established.[2] It is to be observed in Figure 1 that no increase in production of blood occurred after the administration of riboflavin, nicotinic acid, or synthetic vitamin B_6, but that a response occurred when the patient was fed 45 gm. of yeast daily.

The isolation and synthesis of folic acid (Pteroylglutamic acid), a result of the cooperative efforts of Dr. Yellapragada Subbarow, other investigators and the research facilities of the Lederle Laboratories, furnished, for the first time, a pure substance which could apparently produce a hematologic and clinical remission in Addisonian anemia. Although hypotheses have been developed as to the probable physiologic mechanism through which folic acid works, its exact role in hematopoiesis is still a mystery.

One of the reasons for failure to advance knowledge concerning the identity or specificity of liver extracts and related substances has been the lack of any chemical or biological test which might serve to determine the potency of the fractions being investigated. This has been accomplished only by administering material to patients with Addisonian pernicious anemia who are in relapse. Experimental data is now accumulating to show that a bacterium may be used to supply this deficiency. In 1948 Shorb[9] reported the finding that Lactobacillus lactis Dorner, when cultivated in a suitable basal medium, grew when refined liver extract was added to the menstruum. When assays of various commercial liver extracts were carried out by determining the minimum quantity that would support growth, Shorb found an almost linear relationship to the unit potency of the extracts. Recently, Rickes[8] and his associates have isolated a crystalline substance from liver extract in the form of small red needles and Shorb,[10] who assayed its potency value for L. lactis

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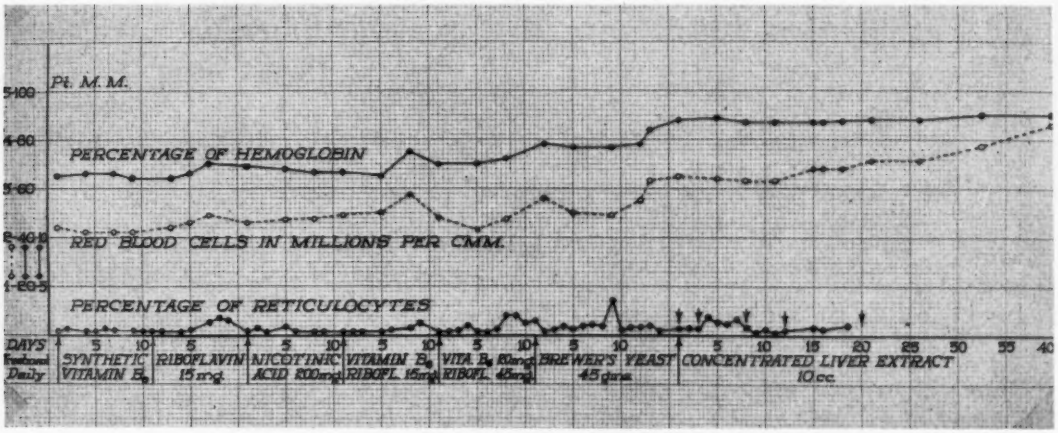

Figure 1.—A case of Addisonian pernicious anemia. Components of the vitamin B complex given by mouth are without hematopoietic effect. There was satisfactory response to 45 gm. daily doses of yeast.

Dorner, found that 0.000013 micrograms per ml. was sufficient to produce half maximal growth of L. lactis in a 23-hour growth period. With respect to weight it was 11,000 times as potent as an arbitrarily selected standard liver extract. This substance has been designated as vitamin B_{12}. West,[13] in 1948, reported that vitamin B_{12} is of great value in the treatment of Addisonian pernicious anemia. Further reports substantiating the effectiveness of vitamin B_{12} in the treatment of pernicious anemia have been published by Spies[11, 12] and Castle.[2]

During the past year on the wards and in the Out-Patient Department of the University of California Medical School, we have had an opportunity to observe the effects of vitamin B_{12} on the anemia and neurological abnormalities of a group of patients with Addisonian pernicious anemia. The case histories including the pertinent physical findings and laboratory data are reported.

GROUP I

This group consists of four cases of uncomplicated pernicious anemia.

CASE REPORTS

CASE 1: A 70-year-old white male was admitted to the medical service of the Out-Patient Department on May 24, 1948. He complained of progressive weakness, pallor, anorexia, and sore tongue of three months' duration. During the preceding four weeks he had become aware of some exertional dyspnea and a desire to sleep a great deal. His appetite was poor and he was frequently nauseated. Friends commented that his skin appeared pale and yellowish. He denied consciousness of numbness and tingling in the fingers or toes, or of instability of gait. There was no known family history of anemia.

On physical examination, the patient appeared slightly obese, and there was a pale yellowish discoloration of the skin. The sclerae was faintly icteric. The tongue was pale and smooth. No other positive findings were elicited. Examination of the central nervous system was also negative.

Erythrocytes numbered 1,370,000 per cu. mm. with a hemoglobin of 6.8 gm. per 100 cc. (47 per cent), and the leukocyte count was 4,600 per cu. mm. The packed cell volume was 20 cc. per 100 cc. of blood. The mean corpuscular volume was 145 cubic microns; mean corpuscular hemoglobin concentration 34 per cent; and the mean corpuscular hemoglobin 49 micro micrograms. The color index was 1.7. The reticulocytes were 0.6 per cent. An analysis of the gastric secretion revealed an absence of free hydrochloric acid and pepsin which persisted following the subcutaneous injection of histamine. Specimens of bone marrow removed by aspiration of the sternal cavity showed marked megaloblastic and erythroblastic hyperplasia.

On the sixth day following examination, treatment with vitamin B_{12} was started by the intramuscular injection of 25 micrograms.* The reticulocytes began to rise on the third day following treatment and reached a peak of 11.6 per cent on the seventh day. At the onset of the reticulocyte rise the patient expressed a feeling of improvement and a return of appetite. On the 16th day following treatment, the erythrocyte count had risen to 2,990,000 per cu. mm. and the hemoglobin to 10.1 gm. per 100 cc. (70 per cent). The reticulocytes returned to a pre-treatment level of 1.6 per cent. Examination of aspirated sternal marrow showed a normal pattern. On this day the patient was given a second injection of 25 micrograms of vitamin B_{12} to determine whether or not a secondary reticulocyte rise could be induced. It is to be observed that there was a rise in the reticulocytes from 0.6 per cent to a peak of 5.2 per cent. Following this the reticulocytes returned to a low level of 0.4 per cent.

Twelve weeks following the initial treatment the erythrocytes numbered 4,100,000 and the hemoglobin content was 12.7 gm. per 100 cc. (92 per cent).

Although the need for continued treatment was emphasized to the patient, he did not return to the clinic for a period of three months. On December 10 he reported to the clinic because of a return of weakness. Erythrocytes numbered 1,580,000 and the hemoglobin was 8 gm. per 100 cc. (57 per cent). Treatment was reinstituted with an injection of 50 micrograms of vitamin B_{12}. There was a repetition of the reticulocyte response and a peak of 13 per cent was recorded on the sixth day. Four weeks following the injection of vitamin B_{12} erythrocytes numbered 3,500,000 and the hemoglobin was 10.8 gm. per 100 cc. (75 per cent). On February 11, 1949 (eighth week) erythrocytes were 4,160,000 and the hemoglobin 14.5 gm. per 100 cc. The data

*Supplied by Dr. Augustus Gibson of Merck & Co., Rahway, New Jersey.

showing this patient's response to vitamin B_{12} appears in Figures 2, 3, and 4.

CASE 2: A white female, aged 28 years, was first observed in the Out-Patient Department in 1933 with a complaint of weakness, palpitation, and dyspnea. There were no paresthesias. Aside from obesity, the physical examination showed no symptoms or signs of clinical significance. There was no clinical evidence of disease of the neurological system. Laboratory studies revealed an erythrocyte count of 2,000,000 per cu. mm.; hemoglobin content 54 per cent of normal (7.5 gm. per 100 cc., Sahli). Achylia gastrica persisted despite the parenteral injection of histamine. The halometer reading (average diameter of the erythrocyte) was 8.3 microns; the saturation index was 1.31. Accordingly, a diagnosis of hypochromic macrocytic anemia was made. The patient responded well to parenteral injections of liver extract. On the 25th day following the institution of therapy, erythrocytes numbered 4,190,000 per cu. mm., and the hemoglobin content was 88 per cent (12.4 gm. per 100 cc. Sahli).

(It is of interest that in 1933 the patient's mother was examined and found to be suffering from hypochromic anemia. The erythrocyte count was 4,170,000 per cu. mm., and the hemoglobin content was 54 per cent (7.5 gm. per 100 cc., Sahli). The mother was reexamined in 1943 at which time she showed the characteristics of Addisonian pernicious anemia).

The patient refused treatment for about three years because of marital difficulties. On October 29, 1948, she was admitted to the Out-Patient Department complaining of weakness and dyspnea on exertion. The erythrocyte count was 1,410,000 per cu. mm. and the hemoglobin 47 per cent (6.8 gm. per 100 cc., Sahli). The mean corpuscular volume was 170 cubic microns; the mean corpuscular hemoglobin 41 micro micrograms; and the mean corpuscular hemoglobin concentration 28 per cent.

The patient was given a parenteral injection of 50 micrograms of vitamin B_{12}. Figure 5 shows response to therapy. It is to be noted that within 24 hours the reticulocytes had risen from 0.8 per cent to 7.6 per cent, and reached a peak of 8.8 per cent in 120 hours (fifth day). The patient was given another injection of 50 micrograms of vitamin B_{12} to determine whether or not a secondary reticulocyte rise could be stimulated. However, this did not occur. Erythrocyte count and hemoglobin attained normal levels in 60 days.

CASE 3: A white male, aged 66 years, reported to the Out-Patient Department on January 6, 1947, complaining of epigastric distress. He stated that he had felt well until seven or eight weeks previously when he first noticed a vague soreness in the epigastrium accompanied by nausea and some gaseous eructation. His weight had averaged 205 pounds until two months previously; at the time of examination it was 192 pounds. The patient was a normally developed, moderately obese man, in no apparent distress. The positive physical findings consisted of a moderate degree of

PERNICIOUS ANEMIA NO I

J.E.R. Age. 70 O.P.D. 48690 U.No. 154124.

DATE	R.B.C.	Hgb % gms.	Ret	Platelets	WBC	
6-1-48	1.57	47-6.8		340,000	4600	o.8 cc vit. B_{12} given i.m o.025 mg/cc
6-2-48	1.48	46-6.6	0.6			o.7 cc vit B_{12} given i.m
6-3-48			2.2			
6-7-48	1.77	54-7.8	11.6			
6-8-48			8.6			
6-9-48	2.31	56-8.1	8.6			
6-10-48			6.4			
6-11-48	2.03	56-8.1	7.2			
6-12-48			3.8			
6-14-48	2.50	64-9.2	4.4	385,000		
6-15-48			1.2			
6-16-48	2.99	70-10.1	1.8			

Figure 2.—*Case 1.* Response of reticulocytes and course of blood counts on parenteral injection of 25 micrograms of vitamin B_{12}.

PERNICIOUS ANEMIA NO II.

J.E.R. Age 70. O.P.D. 48690 U.NO. 154124.

DATE	R.B.C.	Hgb % gms	Ret	Platelets	WBC	
7-16-48	2.87	74-10.7				B_{12} - 10cc i.m. o.025 mg m
7-19-48	2.70	71-10.2	0.6			
7-20-48			3.4			
7-21-48	2.64	77-11.1	4.6			
7-22-48			4.6			
7-23-48	3.39	84-12.1	5.2			
7-28-48	3.07	84-12.1	1.0			
7-29-48			0.4			
8-5-48	3.43	86-12.4		200,000		
8-12-48	3.62	90-13.04		225,000		
8-20-48	3.87	88-12.7				
8-27-48	4.10	92-12.7		380,000		
9-10-48	4.28	84-12.1				

Figure 3.—*Case 1.* Secondary reticulocyte response induced by second injection of 25 micrograms of vitamin B_{12}. Return of red blood cells and hemoglobin within normal range in 60 days.

PERNICIOUS ANEMIA

NAME: J.E.R. AGE: 70 (Re-entry)

DATE	R.B.C.	Hgb. %Gms.	RET	W.B.C.	TREATMENT
12-10-48	1.58	57			Vit. B_{12} .050 mgm. given I.M.
12-13-48	1.91	61	6.0		
12-14-48			10.8		
12-15-48	1.89	60	8.8		
12-16-48			13.0		
12-17-48	2.41	65-9.4	8.4		
12-19-48	2.43	68-9.8			Vit. B_{12} .020 mgm. given I.M.
1-7-49	3.12	79-11.4			
1-10-49	3.50	75-10.8			Vit. B_{12} .050 mgm. given I.M.
1-14-49	3.34	86-12.4		7600	
1-21-49	3.43	85-12.3		7500	.050 mgm. B_{12} given I.M.
1-28-49	4.13	85-12.3		11,050	
2-4-49	4.06	86-12.7		12,650	
2-11-49	4.00	106-15.3			

Figure 4.—*Case 1.* Shows recurrence of anemia four months after last injection of vitamin B_{12} but satisfactory response of blood on further administration of vitamin B_{12}.

PERNICIOUS ANEMIA

(IN RELAPSE)

NAME: E. G. AGE: 43

DATE	R.B.C.	Hgb % Gms.	RET %	W.B.C.	TREATMENT
10-29-48	1.41	47-6.8	0.8	4500	Vit. B_{12} .050 mgm. given I.M.
11-1-48			7.6		
-2-			6.8		
-3-	1.73	57-8.2	8.8	7900	
-4-	2.15	58-8.4	7.0		
-5-	2.28	58-8.4	6.0		
-8-	2.68	72-10.4	6.0		
-9-			0.5		
-10-	2.84	81-11.7	2.6		
-11-			2.6		
-12-	2.91	83-12.0	1.6		Vit. B_{12} .050 mgm. given I.M.
-15-	3.14	84-12.1	1.6		
-16-			0.8		
-17-	3.04	87-12.6	2.2		
-18-			1.2		
-19-	3.12	82-11.8	1.4		
12-31-48	4.37	94-12.9			Vit B_{12} .030 mgm. given I.M.

Figure 5.—*Case 2.* Response of reticulocytes and blood counts to 50 micrograms of vitamin B_{12}. No response of reticulocytes occurred following second injection.

PERNICIOUS ANEMIA

NAME: McC R.M. AGE: 67

DATE	R.B.C.	Hgb % Gms	RET	W.B.C.	TREATMENT
10-6-48	1.01	35-50	1.8	3500	Megaloblastic bone marrow
-9-			3.0		
-10-			2.6		Vit B_{12} .025 mgm. given I.M.
-11-	1.16	44-63	15.2		
-12-			16.2		
-13-	1.60	45-65	19.4		
-14-			16.2		
-15-	2.06	51-73	10.8	5700	
-16-			4.4		
-18-	2.49	61-87	3.2	9250	
-22-	2.59	61-87			
-29-	2.31	64-92	0.2		Vit B_{12} .025 mgm given I.M.
11-1-48	2.84	63-91	0.2		
-4-	3.31	64-92	1.0		
-8-	3.45	80-116	1.2		
12-3-48	3.26	86-124			Patient left clinic

Figure 6.—*Case 3.* An injection of 25 micrograms of B_{12} resulted in an erythropoietic response. Patient left clinic before course of observation completed.

generalized arteriosclerosis associated with a systolic blood pressure of 165 mm. of mercury and a diastolic pressure of 76 mm. The erythrocyte count was 4,660,000 per cu. mm., leukocytes numbered 10,360, and the hemoglobin content was 100 per cent of normal (14.5 gm. per 100 cc., Sahli). Gastric analysis showed a persistent achlorhydria despite the parenteral injection of histamine. Stools were negative for occult blood. Roentgenographic studies revealed no abnormalities in the gastrointestinal tract or gall bladder.

The patient did not return to the Out-Patient Department until October 4, 1948, when he complained of progressively increasing dyspnea of four months' duration, anorexia, and a loss of 35 pounds in weight. His family had observed that his skin had become pale and sallow. There had been no numbness or tingling in the fingers or toes, or soreness of the tongue.

Erythrocytes numbered 1,000,000 per cu. mm.; hemoglobin was 35 per cent (5 gm. per 100 cc.); leukocytes numbered 3,500, and the platelets 150,000 per cubic millimeter. The icterus index was 10 units and the volume of packed red blood cells was 15 cc. per 100 cc. of blood. The mean corpuscular volume was 148 cubic microns; mean corpuscular hemoglobin concentration 33 per cent; and the mean corpuscular hemoglobin 40 micro micrograms. A specimen of sternal marrow was aspirated and examination showed the presence of large numbers of megaloblasts consistent with the diagnosis of pernicious anemia. On October 8, 1948, the patient was given an intramuscular injection of 25 micrograms of vitamin B_{12}. The subsequent reticulocyte response and rise in erythrocytes are recorded in Figure 6. At the end of 48 hours, the reticulocytes had increased from 3 per cent to 15 per cent and reached a peak of 19 per cent at 96 hours. A secondary reticulocyte response did not appear following a second injection of liver extract. Just prior to the end of 60 days of observation, erythrocytes numbered 3,280,000 and the hemoglobin was 85 per cent of normal. At this time it became necessary for the patient to travel some distance so that further counts were not obtainable.

CASE 4: A white, married female, aged 47, was first examined on September 12, 1948, at which time she complained of headache, weakness, loss of weight, swelling of ankles, and palpitation. These symptoms had been getting progressively worse over a period of about four months.

On physical examination it was noted that there was a lemon-yellow color to the skin and pallor of the mucous

Diagnosis: Pernicious Anemia

Name: Mrs. J.P. Age 47

DATE	RBC	Hgb. % Gms.	Ret. %	WBC	TREATMENT
10 8 48	1.64	42-7.1		3400	← 25 Micrograms
9			5.6		B_{12} given
11			7.2		
12			15.		
13			15.8		
14			20.8		
15			11.0		
16			7.6		
18			7.0		
19			4.2		
20	2.75	59-10.0	4.0	4050	
22					← 25 Micrograms
25			1.6		B_{12} given
27	3.28	69-116	2.2	4750	
11-12-48	3.70	74-125		6200	
12-3-48	3.43	10.4		4850	
17	5.33	19.1		10,600	

Figure 7.—*Case 4.* Satisfactory hematopoietic response to 25 micrograms of vitamin B_{12}.

membrane. The tongue appeared smooth. A murmur, systolic in time, was heard in the region of the apex in the heart. The spleen was not enlarged. Erythrocytes numbered 1,640,000 per cu. mm. and the hemoglobin content was 7.1 gm. per 100 cc. (42 per cent). Leukocytes numbered 3,400 per cubic millimeter. Examination of aspirated sternal marrow showed pronounced megaloblastic hyperplasia. The gastric secretion showed an absence of free achlorhydria.

The patient was given 25 micrograms of vitamin B_{12} intramuscularly. In 48 hours the reticulocytes were 7.2 per cent, and in 96 hours had attained a peak of 20.8 per cent. When the reticulocytes had returned to normal numbers, another injection of 25 micrograms of vitamin B_{12} was given. However, a secondary reticulocyte response did not occur. In about 60 days the erythrocyte count and hemoglobin were within normal limits as recorded in Figure 7.

COMMENT ON THE CASES IN GROUP I

It may be seen on study of the charts of these four patients that they all responded well to doses of 50 micrograms or equally well to 25 micrograms of vitamin B_{12}. When the reticulocyte count had fallen, a secondary response was induced in only one patient following a second injection of 25 micrograms of B_{12}. This indicated that in the patients not showing a secondary response the treatment was optimum and was submaximal in the other patient. Improvement was maintained in the patients with injections of 25 micrograms of B_{12} repeated every two weeks. The erythrocytes had returned to within normal range within 60 days in all patients. The one exception (Case 1) was a patient who voluntarily discontinued treatment. At the end of four months, an examination of his blood showed return of anemia of pronounced degree. A second remission resulted from renewed injections of vitamin B_{12}.

GROUP II

Three cases of pernicious anemia complicated by combined system disease.

CASE REPORTS

CASE 5: A 76-year-old white male of Swedish descent entered the San Francisco Hospital in 1944, at which time a diagnosis of pernicious anemia was made. Erythrocytes numbered 680,000 per cu. mm. and the hemoglobin content was 5 gm. per 100 cc. A remission was induced by injection of suitable amounts of liver extract.

The patient entered the San Francisco Hospital for the second time on October 19, 1948, because of recurrence of anemia. It was learned that anemia had been well controlled in the interim by injections of liver extract every three weeks. Four months prior to the present entry, the patient had a "heart attack" which confined him to bed and prevented him from returning to the clinic for needed liver extract therapy. During the previous few weeks he had noticed the occurrence of numbness and tingling in the tips of the fingers and toes.

On physical examination the patient appeared well nourished and well developed. The skin and sclerae were of a lemon-yellow tint. Dyspnea on exertion was obvious. There was generalized arteriosclerosis. A slight increase in the area of cardiac dullness to the left of the midclavicular line was noted. The radial pulse showed gross irregularity as to rate and volume as well as a pulse deficit. The vibratory sense was diminished at the ankles and toes. No abnormalities of the tendon reflexes were elicited.

Examination of the blood showed erythrocytes numbering 870,000 per cu. mm. and hemoglobin of 4.2 gm. per 100 cc. The color index was 1.7. Analysis of the gastric secretion revealed achlorhydria which persisted after the injection of histamine. Aspirated sternal marrow showed pronounced megaloblastic hyperplasia.

On October 23, 1948, 50 micrograms of vitamin B_{12} was injected parenterally. At 48 hours the reticulocytes had risen from 1.3 per cent to 5.3 per cent and in 96 hours had attained a peak of 32 per cent. Examination of the sternal marrow at this time showed erythroblastic and normoblastic hyperplasia. On the 15th day the reticulocytes had returned to pre-treatment level. Erythrocytes numbered 3,000,000 per cu. mm. and hemoglobin was 7.5 gm. per 100 cc. The bone marrow showed a normal myelogram. By this time the patient's ability to discern the vibrations of the tuning fork had returned and the paresthesias of the fingers had disappeared.

Two weeks after the first injection of vitamin B_{12} the patient received a second injection of 50 micrograms to determine whether or not a second reticulocyte rise could be induced. This did not occur.

Sixty days after treatment was instituted, erythrocytes numbered 385,000 per cu. mm., and the hemoglobin was 89 per cent of normal. The disease was complicated at this time by the occurrence of cardiac decompensation for which it was necessary to hospitalize the patient. Data on this patient is shown in Figure 8.

CASE 6: A white male, aged 65, was admitted to the San Francisco Hospital January 28, 1949, complaining of numbness and tingling in the fingers and toes. He stated that two years before entry he had visited a physician because of the appearance of a yellow hue to the skin. A diagnosis of pernicious anemia was made, and he was given injections of liver extract three times a week for two weeks and then once a week for five months. He did not return for continued therapy because he felt sufficiently improved. Eight months following the cessation of the original therapy, there was exacerbation of symptoms, and the patient again consulted a physician. He received injections of liver extract over a period of eight months when, because of a feeling of well-being, he again discontinued treatment.

Six weeks prior to entering the hospital he noticed numbness and tingling of the tips of fingers and toes. This progressed in severity to the point that for the preceding two weeks he had experienced difficulty in walking. He was uncertain as to the stability of his feet, necessitating the watching of his feet while walking. Also, in the preceding two weeks he found it necessary to spread his feet farther apart in order to maintain balance. He also noticed difficulty in writing and in handling small objects.

PERNICIOUS ANEMIA
(IN RELAPSE)
NAME: Mr. L. AGE: 76

DATE	R.B.C.	Hgb. % Gms.	RET	WBC	TREATMENT
10-23-48	870,000	4.2	1.3		Vit B_{12} .050 mgm. given I.M.
-24-			1.9		
-25-	916,000	4.4	5.3		Bone marrow Megaloblastic and Erythroblastic hyperplasia.
-26-			11.0		
-27-	1.52	31-45	32.0		Bone marrow, Erythroblastic and Normoblastic hyperplasia.
-28-			27.0		
-29-	1.63	40-56	22.2	5200	
-30-			16.0		
-31-	2.05	40-56	11.0		
11-1-48	2.32	41-59	14.6		
2			3.8		
3	2.24	61	11.6		
4	2.33	43-64	8.8		
5	2.42	49-70	7.6		
7	2.62	55-80	4.8		Vit B_{12} .050 mgm. I.M.
9	3.04	75	3.8		Bone marrow Normoblastic
12	3.00	58-84	1.1		
17	3.17	68-98	0.2		
12-3-48	3.16	84-121			Bone marrow normal. Vit B_{12} .050 mgm I.M. Hospitalized for Cardiac decompensation.
10	3.39	74			

Figure 8.—*Case 5.* Changes from megaloblastic to normoblastic marrow accompany hematopoietic response. Paresthesias due to combined system disease subsided 15 days after injection of 50 micrograms of vitamin B_{12}.

During the preceding two years his weight had dropped from an average of 185 pounds to 155 pounds. There was no history of sore tongue. There was no history of pernicious anemia in the family.

On physical examination the patient appeared older than his stated age. He was underweight, the hair was white, the skin appeared "lemon-yellow," and there was a mild icteric tint to the sclerae. The tongue appeared smooth and was not "beefy-red" in color. Examination of the nervous system revealed hyperactive biceps and patellar tendon reflexes. The Romberg test was designated as postive. The vibratory sense was diminished over the feet.

Erythrocytes numbered 1,400,000 per cu. mm. and hemoglobin was 4.8 gm. per 100 cc. of blood. The mean corpuscular volume was 109 cubic microns, and the mean corpuscular hemoglobin 40 micro micrograms. A bone marrow specimen aspirated from the sternum contained 37 per cent megaloblasts. The patient had histamine-fast achlorhydria.

On January 28, 1949, the patient was given an intramuscular injection of 50 micrograms of vitamin B_{12}. On this occasion the reticulocytes were 0.7 per cent but within 72 hours had risen to 6.4 per cent. In 96 hours they had attained a peak of 24.4 per cent following which they returned to pre-treatment level. On February 18 the patient received an injection of 25 micrograms of vitamin B_{12}. This was followed by a secondary rise in the reticulocytes to 8 per cent.

Seven days after the first injection of vitamin B_{12}, the patient noticed a lessening of the paresthesias in the hands and feet. At the same time, he began to gain in strength, his gait became more stable, the Romberg was recorded as negative, but no change was noted in the tendon reflexes or vibratory sense.

Diagnosis: Pernicious Anemia

Name: McC.B. Age: 65

DATE	RBC	Hgb. % Gms	Ret %	WBC	PMN S+NF	PME	PMB	LL	Mo.	TREATMENT
1-28-49	1.40		0.7	2700	50-5	1		40	6	← 50 Micrograms
30	900,000	29-43	0.4	3600	37-2		1	36	4	B_{12} given.
31	950,000	32-47	6.4	7700	38-2	3	1	50	6	
2-2-49	2.10	36-52	24.4	2600	26-7	1		61		
4	2.60	45-65	23.5	2800	30-6	2		57	5	
6	2.60	45-65	18.0	4360						
9	3.10	49-70	12.0	5200						
12	3.00	52-75		6200	55-1		2	42		
14	3.20	66-96		6400	62-2	1	1	30	4	
16	3.35	66-96		4900	59-1	1	1	34	4	
18	3.30	69-10								← 25 Micrograms
21	3.41	69-10		6000	60-2		1	35	2	B_{12} given
28	4.41	83-120		7550						

Figure 9.—*Case 6.* Satisfactory hematopoietic response to 50 micrograms of vitamin B_{12}.

Sixty days after treatment was started, erythrocytes numbered 4,410,000 per cu. mm. and the hemoglobin was 83 per cent of normal (12 gm. per 100 cc.).

CASE 7: The patient, a 48-year-old white female, was known to have had pernicious anemia for 15 years with sporadic treatment. When examined on December 16, 1948, she complained of numbness and tingling in the fingers and toes, a loss of sense of position, and difficulty with locomotion.

Examination of the nervous system showed the vibratory sense to be absent from both feet and knees; position sense was absent in both big toes, and the patellar and Achilles tendon reflexes were both exaggerated. They were recorded as 3 plus. Examination of the blood revealed a slight macrocytic anemia. Erythrocytes numbered 3,940,000 per cu. mm. and hemoglobin was 11.4 gm. per 100 cc. (80 per cent). She had histamine-fast achlorhydria. The patient was given intramuscular injections of 50 micrograms of vitamin B_{12} on December 16, 1948, and January 6 and January 31, 1949. Neurological examination on the latter date revealed that the vibratory sense had returned to both knees and both ankles. Position sense had also returned to both great toes. The patient volunteered the information that there had been definite improvement in the gait. The erythrocyte count had increased to 4,430,000 per cu. mm. of blood.

COMMENT ON THE CASES IN GROUP II

In this group of three patients attention is again called to the excellent hematopoietic response to injections of vitamin B_{12}. This is indicated by the increased number of reticulocytes appearing in the peripheral blood within 48 hours and attaining a peak response in 96 hours after treatment was started. In two patients the response was optimum. In one patient (Case 6) the response was submaximal wherein a secondary reticulocyte response appeared following the second injection of vitamin B_{12}.

The neurological symptoms complained of by these patients varied in degree. In one (Case 5) they were minor, and consisted of numbness and tingling of the fingers and toes, and inability to discern the vibrations of a tuning fork over the feet. These symptoms had disappeared entirely by the 15th day following the injection of vitamin B_{12}. In the other two patients, the neurological changes were advanced to a further degree. These consisted not only of paresthesias and loss of vibratory sense, but loss of position sense and disturbances of locomotor function as well. In one patient (Case 6), seven days after treatment was started the paresthesias were greatly diminished and the Romberg test became negative. The vibratory sense, however, remained impaired. In the third patient (Case 7) when examined six weeks after treatment was started, there was return of vibratory sense, return of position sense and pronounced improvement in locomotion.

GROUP III

One case of pernicious anemia complicated by pregnancy and sensitivity to liver extract.

CASE REPORT

CASE 8: The patient, a white female, aged 31, was first examined in May, 1947, when she was found to have macrocytic anemia accompanied by gastric achlorhydria. Erythrocytes numbered 3,200,000 per cu. mm. and hemoglobin was 12.5 gm. per 100 cc. The patient was given intramuscular injections of 40 units of liver extract once a week for six weeks. The reticulocytes attained a peak of 6 per cent and, at the end of this period erythrocytes numbered 4,360,000.

The general condition improved and the patient remained well on injections of 20 units of liver extract every ten days. On November 12, 1948, the patient reported that after each of the last four injections she had suffered considerable pain, redness and swelling at the site of injection, which subsided only after two or three days. The last injection was further complicated by nausea and a generalized urticarial rash. At this time the patient was five months pregnant. It was believed that she had become sensitive to liver extract, and it was necessary to discontinue this form of therapy. On January 6, 1949, erythrocytes had decreased to 3,120,000 per cu. mm. of blood, and hemoglobin to 10 gm. per 100 cc. At this time an intramuscular injection of 25 micrograms of vitamin B_{12} was given. Reticulocytes increased to 12 per cent and on January 20, 1949, erythrocytes numbered 4,340,000 per cu. mm.

COMMENT ON THE CASE IN GROUP III

Case 8 is clearly one of Addisonian pernicious anemia that had been adequately treated on liver extract until the course of the illness became complicated by pregnancy. Subsequently, the patient became sensitive to liver extract and further use of this medication was discouraged. There was an interim of several months when the patient could not be given liver therapy and during which time there was recurrence of anemia of slight degree. When vitamin B_{12} became available as a therapeutic agent for this patient, there was a satisfactory response of the blood following an injection of 25 micrograms. There were no signs of drug sensitivity, such as were exhibited when liver extract was given.

DISCUSSION

In the eight patients whose case histories have been reported here, satisfactory hematopoietic response occurred in all following an initial injection of 25 or 50 micrograms of vitamin B_{12}. An increase in reticulocytes became apparent in the peripheral blood usually within 48 hours and peak response was attained within 96 hours. In these patients the peak of the reticulocyte response ranged from as low as 9 per cent to as high as 32 per cent. In none of the patients were there the maximal reticulocytoses up to 40 per cent or more as indicated by Isaacs' formula (i.e., the greater the degree of anemia, the more pronounced should be the reticulocyte response). It is well known that such factors as

arteriosclerosis or low grade infection may modify reticulocyte response. However, the conversion of the bone marrow from one of the megaloblastic (rubriblastic) hyperplasia to one of normoblastic (metarubriblastic) distribution accompanied by a return of erythrocytes and hemoglobin to normal levels within 60 days indicates that satisfactory remission had been induced.

No better initial response is likely to be obtained in an uncomplicated case of Addisonian pernicious anemia by giving larger doses of vitamin B_{12} than those used in the cases reported. Since two of the patients, one having received 50 micrograms and the other 25 micrograms as initial injections, showed secondary reticulocyte response on second injections of similar amounts, it may be stated that some patients will require greater amounts than others to produce absolute optimal effects. Experience in the use of vitamin B_{12} in a larger group of patients will be required to help solve this problem.

Some investigators recommend that vitamin B_{12} should be given in certain dosage (e.g., 10 micrograms once or twice a week) in order to obtain satisfactory remission and maintain the blood cell count at normal levels. Information at hand suggests that vitamin B_{12} is the effective agent in liver extract and that its action is similar to that of liver extract. It may be well, therefore, to adopt criteria which have been applied to liver extract and give larger individual dose injections at longer intervals rather than smaller doses at frequent intervals. Clinical studies imply that the anti-pernicious anemia activity of one microgram of vitamin B_{12} is approximately equivalent to that of one U.S.P. unit of liver extract (Rickes). The intramuscular injection of 60 micrograms of vitamin B_{12} should be the minimal amount to effect a satisfactory reticulocyte rise and cause a return of the blood to normal in 60 days.

In preliminary work the authors have started out with initial doses of 50 micrograms but more recently have reduced this to 25 micrograms, to be repeated every two weeks until the blood has returned to normal. An injection of 30 to 50 micrograms at intervals of one month should be adequate to maintain normal erythrocyte and hemoglobin content in the blood.

Originally it was found that, in the treatment of Addisonian pernicious anemia with raw liver, the early manifestations of combined system disease were arrested or completely abated in due course of time. In the process of purification of liver extract, it was thought that this activity might be lost in the discarded side-fraction or might be totally destroyed. This was not entirely so. Although some of the factors may have been removed during the process of concentration, liver extracts on the whole have served well in ameliorating or stopping progression of the combined system disease. Unfortunately, this has not been the case with folic acid. Clinical experience has taught that this is not a safe drug to use in the treatment of pernicious anemia because it does not have a curative effect on the combined system disease or prevent its development.

With regard to vitamin B_{12}, our experience is in keeping with that of Castle[2] and Spies[12] that in the cases of early combined system disease there is prompt relief from the paresthesias arising from degeneration of the posterior columns. In patients with moderately advanced disease, there may be complete relief of paresthesias and amelioration or complete disappearance of symptoms arising from the lateral descending pyramidal tract.

At present under observation is a group of patients whose paresthesias, loss of vibratory sense and spasticity of gait have persisted in spite of large doses of liver extract. Recently, these patients have been given injections of vitamin B_{12}. Objectively, little change can be detected in their condition, but their spontaneous admissions are to the effect that they feel better and have noticed improvement in locomotion.

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Psychotherapy of Functional Dermatoses

Its Value and Limitations as Applied to Neurodermatitis

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SUMMARY

Etiologically, neurodermatitis is interpreted as an often manifestly hereditary diathesis which is frequently complicated and exacerbated by disturbances of the patient's emotional and psychic structure. The following traits are commonly exhibited, singly or in combination: a tendency toward excitability and an exaggerated capacity for response to stimuli, polyvalent dermal hypersensitivity, a propensity to vascular disturbances, a personality somewhat obsessional in structure and evidence of deep-seated emotional conflict.

Shallow psychotherapy, an indispensable adjunct to the treatment of neurodermatitis, can be successfully applied by any dermatologic physician adequately endowed with patience, sympathy and tact. This method does not achieve a cure, but, properly applied, it can immeasurably improve the patient's lot.

IN the six years that have passed since the author discussed "Functional Factors in Common Dermatoses" before a meeting of the California Medical Association, there has been time for ideas to mature, to enlarge and to be modified. Meanwhile, thoroughgoing experimental studies on the pathologic changes underlying functional disease and psychiatric investigations of the symptom complexes associated with certain dermatoses have been carried out, and a number of leaders in the field of dermatology have come to an acceptance of a concept of psychogenic factors with regard to diseases of the skin. Yet the author often is confronted by dermatologists who, although recognizing the importance of non-somatic factors in certain cases, say that they have not succeeded in the treatment indicated.

Believing that this lack of success stems from lack of full appreciation of the multiple emotional factors which contribute to the genesis and continuance of the dermatosis in such cases, the author feels that it might be worth while to consider, as a guide, his own interpretation of the etiological structure and views as to therapy of neurodermatitis of the dry type. This disease, although by no means the only cutaneous disorder in which functional factors play an important role, has been chosen as an example because of its prevalence and recalcitrance and because the patient who has it is likely to have a hostile attitude which poses particular difficulties for the physician.

Rational therapy must be based on well formulated etiologic concepts. In the author's opinion, the patient with neurodermatitis often has a manifestly hereditary diathesis, which no method so far discovered can rationally be expected completely to overcome. However, neurodermatitis is frequently complicated and exacerbated by disturbances of the emotional and psychic structure of the patient, and these aggravating disturbances are often amenable to therapy.

The patient with neurodermatitis frequently exhibits one or more of the following traits:

1. A tendency toward excitability and an exaggerated capacity for response to stimuli, features which were pointed out in 1940 by Becker and Obermayer[1] and subsequently emphasized by many investigators.

2. The frequent presence of polyvalent dermal hypersensitivity. The threshold of such allergic responses is raised or lowered by the emotional tension of the patient.

3. A propensity to vascular disturbance, which may assume diverse forms. The abnormal state may be reflected in vascular spasms stemming from adrenergic impulses and clinically discernible as pallor, or it may be expressed by abnormal prolonged vasodilatation consequent to cholinergic impulses and resulting in an increase of all signs of cutaneous inflammation and a decrease in the threshold of pruritus. Experiments have shown that attacks of vascular disturbance in such patients may be precipitated by the upsurge of such emotions as fear, distress, self-pity and apprehension. It is easy to understand, then, why the patient with neurodermatitis has periodic exacerbations and recurrences of the disease, for such a patient is prone to undergo emotional upheavals which inexorably affect the state of his skin.

4. A personality somewhat obsessional in structure. As the author has stated before,[3] the patient with neurodermatitis is manifestly "high-strung" and tense. Exaggerated ambition is reflected in an

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energetic "high-pressure" approach, in the assumption of unnecessary burdens, and in an over-serious attitude toward responsibilities. Such a patient is proclived to activity, and he may be so persistent and exacting that one realizes his goal approaches perfection. His intelligence is often above average; in some instances his inner instability is masked by outward calm.

5. Frequent evidence of a deep-seated emotional conflict stemming from early childhood. Recent psychiatric studies[2, 4] have shown that the patient often has suppressed hostility toward the mother, a profound belief that he is unloved and unlovable, and a fear of being close to or of being touched by anyone; he often derives satisfaction from his suffering. These are features which highly complicate sexual adjustment.

To one who has been made aware of the significance of these traits the necessity for psychotherapy is obvious. There are two kinds: a deep probing of the mind, which only the psychiatrist can carry out, and shallow psychotherapy, which any dermatologic physician who has the prime requirements of intelligent sympathy, understanding and patience can practice.

Deep psychotherapy, in the form of psychoanalysis, fulfills a double purpose in that it offers assistance to the patient who has a true psychoneurosis and affords a means of gaining further much-needed knowledge of the emotional conflicts associated with dermatosis. From the relatively small number of analyzed patients with neurodermatitis, much has been learned. In addition to the facts mentioned before, a hostile, destructive attitude toward the analysis was frequently uncovered. The presence of such hostility, whether open or veiled, must be especially heeded and understood by the dermatologic practitioner if he hopes to enlist the patient's full cooperation.

Psychoanalysis, even in its abbreviated and modified forms, remains at the present time, for economic reasons, the method for a privileged few. However, even if psychoanalysis were adapted to large-scale use in treating the dermatosis, it would have limited applicability, for lasting beneficial results have so far been obtained when the dermatosis first appeared after the patient had reached adulthood. When the disease has been present since childhood, response to deep psychotherapy has been poor. In other words, the earlier the constitutional diathesis appears and the more pronounced its manifestations, the less can be expected, therapeutically speaking.

Shallow psychotherapy, on the other hand, does not aim at unravelling the deep-seated emotional conflicts of the subconscious mind. It strives to provide the patient with an acceptable emotional outlet, through his "transference" to the physician, and to enlist his cooperation in bringing about a rational reorganization of his activities. The physician who is applying shallow psychotherapy must be willing to listen to the patient at all times without interrupting; one of the aims is to relieve the patient's anxiety about the feelings of hostility directed toward a mate or a parent, a goal which may be achieved by patiently explaining the phenomenon of "ambivalence," that is, the propensity to both love and hate another person at the same time. Distress can often be alleviated if it is pointed out that parents are not intrinsically sacrosanct beings and that one need not feel guilty about experiencing hostility toward them.

The patient who is depressed and discouraged about the illness must be freely offered reassurance and encouragement. Every patient must be helped to gain a perspective of his needs and interests, and he must be given sound, practical advice about restoring equilibrium to an often irrationally organized life. The physician can frequently help to eliminate causes of friction by interviewing marital partners or relatives in order to give them some understanding of the patient's problems and by suggesting alterations in living arrangements. The patient must be helped to outline a regime which will provide for adequate rest, including regular sleeping hours and, if possible, a daily nap, and a sensible balance between work and play. It is helpful to stress the value of restful vacations. In addition, mild sedation is frequently indicated, for it has been shown experimentally that barbiturates, like reassurance, persuasion and the gaining of insight, by exerting a remarkably depressive effect on the improperly controlled hypothalamic centers, can prevent overstimulation and consequent vasodilatation.

THREEFOLD EFFECTS OF PSYCHOTHERAPY

It has been the author's experience that if such psychotherapeutic measures are applied in addition to the generally accepted dermatologic methods of therapy the effects are threefold:

1. The initial sympathetic interview affords the patient a long needed emotional catharsis, which is followed almost immediately by symptomatic improvement.

2. This initial improvement, though often short-lived, makes it possible for the physician to enlist the patient's confidence so fully that he is enabled to accept advice and management to a far greater extent than his ordinarily hostile attitude would permit. The physician becomes a much needed "emotional crutch."

3. The patient loses his fear of the disease. He ceases hunting for the magic remedy and learns to live with the dermatosis. The insight which he has gained into his problems and his understanding of the cause and effect sequence in the disease help him to avoid the piling up of emotional tension which causes acute exacerbations.

These are the values and limitations of shallow psychotherapy as the author has been practicing it. This method, as one would expect, does not cure the disease, but since it restores a degree of functional stability to the patient his lot is immeasurably improved. The dermatologic physician who fails to

obtain comparably satisfactory results with the application of psychotherapy should critically examine the approach and technique he has used with his patients. A prodigious amount of patience, sympathy and tact must be expended during the therapeutic interviews of patients with neurodermatitis. The physician who is unable or unwilling to give them in full measure cannot expect to achieve a full measure of success.

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The Changing Outlook in Coronary Disease

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SUMMARY

The statistical prognosis for patients who survive a first attack of coronary thrombosis, as regards both life expectancy and ability to return to normal activity, has been greatly improved in recent years. In the light of advances in understanding of the physiology of the heart and improvements in therapeutic methods, physicians must reevaluate ideas of what a patient should be permitted to do after recovery from an initial attack. Often a return to normal pursuits may be better for the patient than drastic restriction of activity, particularly because of the psychological and emotional effects of invalidism.

In deciding what advice to give on this score, the physician should consider in each case not only the actual amount of coronary circulation but such factors as the patient's temperament, type of occupation and economic status. The goal should be to guide each patient back to usefulness within the limits of his cardiac reserve.

PHYSICIANS and patients of the present generation are well aware that heart disease is the most common cause of death in the United States. Are they conscious, as well, of the more favorable outlook afforded to persons who have acute attacks of coronary thrombosis? For many years victims of coronary disease have been so instilled with a fear of sudden death or a dread of permanent invalidism that the ensuing psychological effects have seriously limited physicians in providing the proper care and rehabilitation for these patients.

While it is true that 15 to 25 per cent of patients with coronary thrombosis die of the first attack, the work of cardiologists who have recently examined the records of patients known to have survived this danger period indicates urgent need for a reevaluation of prognosis in this disease. Emphasis should be placed on a more optimistic outlook with regard to the life expectancy of the patient, and, even more important, physicians must recognize that a return to a certain amount of normal activity may be permitted in many cases.

Not only has the modern physician's ability to make a prompt diagnosis of coronary thrombosis contributed to the changing outlook in this disease, but the distinct advance in treatment which has been made during the past few years has further increased the chances for recovery of the patient. Recent studies on the graphic interpretation of the anatomy of the coronary circulation have made for a better understanding of the physiology of the heart, which in turn has led to new methods which now enable the physician to decrease the incidence of embolic phenomena in some cases and to save lives in others in which emboli have already developed. Therapeutic methods have been importantly improved by the development of the anticoagulants, dicoumarol and heparin.

No single condition in clinical medicine presents a more difficult problem in prognosis than coronary disease. Because of the complexity of the individual factors involved, and because the amount of damage done to the heart cannot be determined from clinical tests alone, prognosis must be based largely on the consideration of each patient's functional capacity.

The underlying basis of the coronary sclerosis and the manner in which it has developed are the determining factors in the physician's estimate of the patient's life expectancy. The task is to discover the degree of coronary insufficiency and to determine whether the disease is pursuing a progressive or non-progressive course. If the obliterative process has been gradual, permitting the compensatory mechanism of anastomosis to come into play, the heart may be enabled to create new channels which would insure an adequate collateral blood supply and serve not only to prevent severe shock but to limit the size of the infarct as well.

Although coronary disease occurs predominately in middle age, it can and does occur at various ages and in persons of all occupations. The fact that attacks of coronary thrombosis have long been known to be more prevalent among intelligent persons occupying positions of responsibility lends credence to the belief that those who are subject to irregular living habits and excessive mental and emotional strain are more vulnerable to this malady. Ultimate prognosis is generally poor if the patient is over 60 years of age at the time of onset, or if obesity is present, or multiple attacks have occurred, or angina pectoris has preceded the attack. On the other hand, ultimate prognosis is favorable if the patient is in the younger age group and there is evidence that the disease of the vessels has been arrested and an anastomotic circulation has developed.

Competent cardiologists now discredit past beliefs that the influence of activity and a return to work exerted a dire effect on the subsequent course of coronary disease. It is no longer felt that the presence of coronary disease, in any or all of its manifestations, does, in itself, necessitate a permanent withdrawal from normal activity. Therefore,

the present day consensus has reversed the viewpoint that susceptibility to attack, to heart failure, angina, and, ultimately, to death are increased by moderate exertion. It has been found that the majority of patients can begin gradual resumption of former activities as early as three months following the initial attack, although in this respect each case must be judged in the light of the individual factors involved.

The physician will encounter difficulties in determining the amount of activity the patient can tolerate if he relies solely on an estimation of the anatomical changes which have occurred, or on the electrocardiographic records, which are inclined to show variance. His opinion should be based almost entirely on his approximation of the actual amount of coronary circulation present and on whether it is sufficient to provide for the ordinary effort in which the patient indulges. Whereas the appearance of mild symptoms upon the resumption of work can, at times, be looked upon as no cause for alarm, it is important that the patient who resumes his former occupation should be free from any evidences of angina or heart failure. Statistics have proved that effort has no appreciable effect in producing recurrent attacks of coronary thrombosis. It is, nevertheless, very difficult to convince the layman that an attack, which may have occurred during the work hours, was due more probably to cardiac weakness caused by the physical inactivity and under-nutrition during the period of the patient's unemployment, than to the actual physical exertion.

No single standard can be applied to an individual case. A broad outlook that takes into consideration such factors as the patient's temperament, type of occupation and economic status is necessary in the estimation of each indivdual's capacity for rehabilitation. The goal in every case, however, should be to guide the patient back to usefulness within the limits of his cardiac reserve. The physician must recognize the danger in, and do his utmost to combat the tendency toward cardiac neurosis which may render the patient completely unable to carry on a gainful occupation which his heart could stand or, indeed, from which it might even benefit. The patient must be convinced by the sympathetic attitude and careful explanation of the physician that mental and emotional strain, rather than physical effort, are the factors which tend to shorten his life, and he must be made to realize that mild activity and moderate living will benefit rather than harm him.

For companies in the field of industry and disability insurance, the determination of responsibilities regarding the support of patients with coronary disease has long been considered difficult. Uncertainty and varying points of view with regard to the establishment of definite criteria concerning the total or permanent disability of the patient, and conflicting prognoses of the past, have made it difficult for these companies to distinguish between persons deserving of disability payments and those whom they have often found themselves forced to support for years after a physician had estimated the prognosis as hopeless.

In the light of recent advances which have led to the conclusion that prognosis may be favorable for 75 per cent of persons who survive an initial acute myocardial infarction, the question of whether the patient shall return to his former occupation has been made a new and more pressing responsibility for the physician. It is, therefore, not only out of concern for the patient, whose life might be made, unnecessarily, a tragedy of fearfulness and inactivity, but out of fairness to employers and insurance organizations, as well, that physicians must personally re-evaluate this problem and consider it their duty to impress their patients with the new and changing outlook in coronary disease.

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Crossed Leg Palsy

With Report of a Recurrent Case

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SUMMARY

A form of peroneal palsy may be caused by crossing the legs. Two physical factors—pressure and tension—are the basic causes, although other factors may be contributory. Direct pressure is applied by the bones of the two legs, compressing the peroneal nerve between them at its superficial part near the head and neck of the fibula.

The palsy may be overlooked as an integral part of a widespread disorder so that careful evaluation and observation of the patient's habits are required. Detection becomes especially difficult when the palsy is bilateral, for then the lesion by virtue of its symmetry blends more readily with associated polyneuritis. A case of recurrent peroneal palsy due to crossing the legs in a prolonged postoperative convalescence is reported in detail.

CROSSING the legs when seated is extremely common and yet the foot drop it causes is by comparison very rare. In some circumstances, when the subject in this position exposes the peroneal nerve to prolonged pressure, crossed leg paralysis may result. In the normal subject the nerve is protected by soft parts except for the superficial inch or two near the head and neck of the fibula. There it may be injured by plaster casts, adhesive tape, or prolonged pressure on the operating room table or in delivery room stirrups, and peroneal paralysis may result.

Textbooks discuss these causes of peroneal palsy but even recent ones do little more than mention crossing the legs as a cause. Nielsen,[7] for example, states, "The nerve is usually injured in its exposed position as it winds around the head of the fibula by crossing the knees," but, like other texts, his does not describe the background of these cases. For the details we must turn to the literature, especially the contributions by Woltman,[9] who reported the first comprehensive study (27 civilians, in 1929), and the latest by Nagler and Rangell[6] (eight soldiers, in 1947). Laird and Mueller[5] called it "bombardier's palsy" but it was found also in other soldiers who were not bombardiers.[6] As Woltman found a farmer, stenographer, auctioneer, professional golfer, jeweler, and a blacksmith among the afflicted, occupation cannot be considered a predisposing factor. The lesion is also found in the unemployed, and their very unemployment may be a contributory factor, for ". . . man is not always occupied, and when he is not, he enjoys the unique privilege of crossing his knees with the result that the peroneal nerve is often wedged between the head of the ipsilateral fibula and the external condyle of the heterolateral femur and the heterolateral patella."[9] It may occur even when one falls asleep with the legs crossed.[4]

CONVALESCENTS SUSCEPTIBLE

Peroneal palsy may be found in convalescents. Paget[8] in 1876 reported it in convalescence from typhoid. Bing[1] reported a case in a patient convalescent from nasal diphtheria who sat a long time in a physician's waiting room with his knees crossed. Most of the 27 cases reported by Woltman were in patients convalescing in a hospital. Sitting idly, the convalescent is likely to keep his legs crossed for unusually long periods. In a case observed by the author the lesion developed first in a patient soon after operation, with recurrence five months later in the same convalescence. In discussing the role of an operation, Woltman[9] said, "In surgical cases it appeared more frequently before operations than after, regardless of the type of operation and of the presence of infection."

A paralysis so easily prevented should not recur, and it seldom does. The following case is reported because only one other in which there was recurrence is recorded in the literature—the sixth of the eight cases reported by Nagler and Rangell.[6] It is not stated how long after recovery the paralysis recurred in that case, but in the case observed by the author it was five months.

ETIOLOGY

Pressure alone may cause the paralysis when the nerve is in direct contact with the bones of both legs, but only when certain predisposing factors exist. Woltman's[9] patients were in the fourth or fifth decade of life, were inactive because of illness, had lost considerable weight, and had other contributory factors causing neuritis. In contrast, Nagler and Rangell[6] reported most of their patients were in the 30-40 age group, were actively engaged (and activity rather than inactivity played an important part), and were generally healthy (only 25 per cent had lost weight). Probably more pertinent to the problem is the observation by Nagler and Rangell that when pyknic, short-legged persons cross their legs there is as much as six inches between the neck of the fibula (with the peroneal nerve around it) and the point at which the legs are crossed. Thus the

peroneal nerve is not compressed between them. But persons of the daddy-long-legs type can and do cross their legs in such a way that the point of intersection is higher and the peroneal nerve subjected to pressure. Their patients were tall (average height 71½ inches), thin, and long-legged. In squatting or kneeling at work they stretched the peroneal nerve, causing ischemia. Direct pressure on the nerve between the bones of the two legs, when they sat with legs crossed, always caused ischemia.

WEIGHT LOSS A PREDISPOSING FACTOR

Tall, thin persons, however, are not alone in predisposition to the lesion. Palsy of this origin occurs in others as well, when severe loss of weight so alters the body contour that the peroneal nerve, possibly already debilitated and more sensitive to injury as corollary of the factors that caused the weight loss, may be compressed when the legs are crossed. Close inspection of subjects seated with legs crossed shows that those in whom paralysis develops literally wind one leg around the other so that the nerve is stretched when the crossed leg hugs the straight leg. Then the position becomes pathogenic, for the "hugging" and "winding" cause, respectively, pressure and tension which are simultaneous and prolonged, both injurious to the nerve. Nagler and Rangell pointed out that kneeling and squatting create tension, and that sitting with legs crossed exposes the nerve to direct pressure. They did not, however, emphasize that both the stretching and pressure can occur at the same time in the single act of sitting with legs crossed, and that this becomes possible in a person of any skeletal type who has lost enough weight to permit proximation of the bones of the two legs.

CASE REPORT

The patient, a white male 51 years of age, complained of weakness in the right foot and numbness in the ankle. In walking the right foot slapped the floor and had to be lifted higher than the left to prevent its scraping. The patient could not dorsiflex the right foot nor extend the toes. Five months previously identical paralysis had occurred during convalescence soon after gastrectomy but had cleared up after two weeks of vitamin injections.

The patient, who was 69 inches in height, had lost 35 pounds in weight postoperatively and had regained only 10. Appetite was poor and there had been diarrhea intermittently for several months. The buttocks had wasted away, the thighs had poor muscle tone, and the muscle bellies in front of and below the knees were wasted and hollow. Although the paralysis was unilateral, the two limbs were symmetrical. Sphincter tone and control were intact. There were no sensory changes in the saddle area. Position and vibration sensation were normal. The patient could stand on the left leg alone to test position sensation, but not on the right. Pin prick and light touch sensation were impaired in the lower anterolateral aspect of the right leg, and more so on the dorsum of the foot and ankle. No sensory changes were found in the left leg. Pressing the peroneal nerve against the fibula produced a painful sensation in the left leg and foot but not in the right. The deep reflexes, hyperactive at the knees, were barely elicited at the ankles in the Oppenheim position, and then only with reinforcements.

Although there was complaint of tingling and numbness in the fingers and hands, there were no objective findings in the upper limbs. The pupils were slightly unequal and scarcely reacted to light. The left disc showed questionable pallor with a clearly defined nasal margin; the right was normal. No abnormalities were elicited in other cranial tests.

Occupational stress was not a factor. For many years the patient had operated a complicated paper manufacturing machine, a block long, servicing it as a machinist. Ill health had never kept him away from work. He had returned to work three months postoperatively but found he was too weak. When the foot drop recurred he stayed indoors to avoid uneven ground.

The diagnosis was polyneuritis caused by prolonged disturbances in alimentation and made worse by a postoperative "dumping syndrome" and diarrhea which further depleted low vitamin reserves. But the advanced isolated paralysis was not in harmony with the symmetry of the polyneuritis. It was difficult to explain this until it was noted that when the patient crossed his legs, he literally "wrapped" the right leg around the left, covering it from knee to ankle. It was a life-long habit, he said, and he always placed the right leg on the left. Preoperatively he had been unable to keep this position for an extended time, but with the postoperative weight loss he could rest one leg comfortably and snugly against the other for hours at a time. The patient recalled that just before the paralysis recurred he had sat this way for four hours in a poker game. Moreover, as his legs had been wedged firmly between the chair and the table, it is probable that the prolonged pressure on the nerve was greater than it might otherwise have been.

The patient was told to have his wife and friends remind him of it whenever he crossed his legs, since he continued to do it even after being cautioned against it. Thiamin chloride, 50 mg., was given thrice daily, and nicotinic acid for its vasodilator effect; also massage with frequent immersion of the affected foot in a bucket of hot water. The foot was rested against a box when the patient was reclining, in order to minimize stretching of the weakened muscles. The patient gained a pound a week. First the numbness left; then the gait improved. In two months the hollows below the knees began to fill in, and the numbness of the fingers was felt only in cool weather. In three months, recovery was complete and the patient returned to work.

DIFFERENTIAL DIAGNOSIS

So selective a paralysis should not be, but sometimes is, a diagnostic problem. For example, in one of the cases reported by Nagler and Rangell[6] the patient had extensive acute polyradiculoneuritis of Guillain-Barré with lower motor neuron disease, and the peroneal palsy was much more profound than the rest of the weakness. The peroneal palsy could easily have been diagnosed incorrectly as an integral part of the polyradiculoneuritis. In the author's case, such an error was made for a while. The error may become serious, for in a case reported by Eaton,[3] it "almost led to needless laminectomy." Nagler and Rangell made a similar observation: "In one case suspicion of disease of the spinal cord led to extensive investigation and almost to needless laminectomy, while in two others functional diagnoses were made and psychotherapy given for long periods prior to accurate diagnosis." Accurate diagnosis is even more difficult when the syndrome is bilateral, for then it blends with the symmetry of polyneuritis. As Dunning[2] reported one such case and Woltman found bilateral peroneal palsy in five cases in a series of 27, the bilateral lesion cannot be

considered a rarity. A history of venereal disease in the presence of such a paralysis and of obscure extensive neurological signs may tempt one to consider the lesion syphilitic, but spinal fluid examination clarifies the issue. In 25 per cent of Nagler and Rangell's[6] cases, physicians had tentatively considered hysteria when no other apparent cause could be found.

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CASE REPORTS

Primary Systemic Amyloidosis

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PRIMARY systemic amyloidosis is a well-defined but infrequently observed disease. Since fewer than 50 cases have been reported[6, 8] to date, and the difficulties in arriving at a correct diagnosis are enhanced by variation in location of the amyloid deposit,[8] an attempt at further correlation of clinical and pathological findings seems warranted.

CASE REPORT

Clinical History: A 54-year-old white male entered the hospital on March 22, 1947, as a transfer from a Naval hospital where he had been since August, 1946. The patient had been in good health, working as an automobile mechanic, up to January, 1946, when he had an acute illness characterized by fever, generalized aches and pains, and shortness of breath. He was hospitalized for one month and the illness was supposedly diagnosed as "flu." He returned to work and remained in good health until August 1946 when epigastric pain, nausea, and vomiting developed. A gastro-intestinal roentgenogram at the Naval hospital was reported as showing duodenal irritability. On a Sippy regimen, the patient improved and subsequent gastro-intestinal roentgenograms were normal. In September 1946 shooting pains in both arms and legs developed with a superficial burning sensation in the hands and feet. Progressive muscle weakness in all four extremities was noted, with pronounced edema of the legs, and the patient complained of frequency of urination. The blood pressure was low and electrocardiograms showed low voltage with inversion of T waves. Results of Wassermann test of the spinal fluid were questionably positive on one occasion and negative on repeat examination. The spinal fluid protein content was 60 mg. per 100 cc. and the colloidal gold curve was negative. Considered to have syphilis of the central nervous system, the patient was given a course of penicillin and then transferred to this hospital.

The past history was essentially negative. Syphilis was denied.

Physical Examination: On admission the patient appeared to be undernourished and chronically ill. The skin and mucous membranes were pale. There was no lymphadenopathy. The pupils were irregular, dilated, did not react to light but did react to accommodation. The cranial nerves were otherwise intact. The heart was not enlarged to percussion. On admission the heart sounds were inaudible to all examiners. Blood pressure was 82 mm. of mercury systolic and 64 mm. diastolic. Subsequently the heart sounds could be heard but were very faint. The rhythm was regular. The lungs were clear. There was some tenderness in the right upper quadrant of the abdomen, but no organs were felt. There was pronounced atrophy of all the muscle groups in all four extremities. There was almost complete loss of muscle power in both lower extremities and at least 50 per cent loss in both upper extremities. Fibrillary twitchings were visible. There was a "glove and stocking" type of hypesthesia present. All deep reflexes were absent. There were no pathological reflexes. Position sense and vibratory sense were intact. There was marked pitting edema in both lower extremities.

Laboratory Examinations: Examination of the blood revealed the following: Hemoglobin 10.7 gm. per 100 cc.; erythrocytes 3.75 million; leukocytes 6,900 with normal differential; mean corpuscular volume 88 cubic microns; mean corpuscular hemoglobin 30 micromicrograms; mean corpuscular hemoglobin concentration 33 per cent. Blood proteins: Albumin, 2.63 gm. per 100 cc.; globulin, 2.99 gm. per 100 cc.; albumin-globulin ratio, 0.88:1. The Kahn test was negative. The urine contained a heavy trace of albumin with occasional hyaline casts and rare erythrocytes. The specific gravity was fixed at a low level. The phenolsulfonephthalein test showed 15 per cent excretion in two hours. The average 24-hour urinary albumin was 5.0 gm. Blood urea was 33 mg. per 100 cc.

Gastric analysis showed a normal free and total acidity. Roentgenograms of the entire gastro-intestinal tract showed no abnormality. Excretory urograms showed poor dye excretion, but no other abnormality. An x-ray film of the chest revealed no abnormality, and fluoroscopy of the heart revealed a normal cardiac outline with normal pulsations.

The electrocardiograms showed a rate of 75; sinus rhythm; PR interval 0.2 second; QRS interval 0.08 second; there was low voltage of all the QRS complexes, and the T waves were flattened in all leads.

Course: It was felt that the patient did not have central nervous system syphilis, and a diagnosis of Guillain-Barré syndrome was considered. Physiotherapy was given but resulted in little improvement of muscle power. Because of the low blood pressure, inaudible heart sounds and electrocardiographic findings, pericarditis with effusion was considered until cardiac fluoroscopy ruled it out. The circulation time with Decholin was 20 seconds. The patient was digitalized with only slight improvement.

The anemia was progressive, the erythrocyte count dropping to 2.87 million and the hemoglobin to 7.2 gm. per 100 cc. Liver and iron therapy and repeated blood transfusions brought no improvement.

An attempt was made to correct the hypoproteinemia with repeated plasma transfusions, but this also was unsuccessful.

The patient complained periodically of epigastric pain, nausea and vomiting. Constipation was persistent. During the last two months of life the patient complained of dryness of the mouth and thickness of the tongue. Visible enlargement of the tongue was noted. Dysphonia and dysphagia developed and became progressively more severe. In the last month of life urinary retention developed and catheteriza-

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tion was necessary. It was the opinion of the genito-urinary consultant that this was due to the primary neurological disease. Death occurred suddenly on November 21, 1947.

Necropsy Findings: Autopsy was performed 15 hours after death. The skin was pale, turgid, and free of lesions. The tongue was large and coated. The abdominal cavity contained 500 ml. and the pleural spaces each 300 ml. of cloudy yellow fluid. The lungs grossly were intact. The heart was large and weighed 620 gm. The right and left ventricular walls contributed equally to the increase in size, measuring 10 and 12 mm. respectively. The cut surface of the heart muscle was of brown red, uniformly waxy appearance. The spleen weighed 540 gm. It showed a smooth dark purple, diffusely waxy surface. The malpighian corpuscles could not be made out. The liver weighed 2,700 gm. Its edges were rounded. The lobular architecture was well preserved. Although kidneys were not enlarged, the cortex was narrow and of yellowish color with the architecture blurred, and numerous indented scars were present on the surface. The iodine test for amyloid carried out on heart, spleen, liver, and kidneys was negative. The other organs were grossly free of lesions save for arteriosclerotic changes of the aorta and of the vessels at the base of the brain.

Lungs: The media of several small vessels was partly replaced by an amorphous homogeneously pink-staining material.

Heart: The fibrillary structure was in many places poorly preserved or not visible at all. In many instances, the muscle fibres were spread apart or surrounded, sometimes compressed by irregularly arranged waxy pink-staining fibres. In places, similarly staining globules replaced muscle fibres partly or entirely. An identical material was seen in many branches of the coronary vessels, replacing largely the media. Fine pink fibres enlarged also the subintimal space narrowing the lumen. Congo red stained only the material in the vascular walls. In a Masson stain the acellular fibres took up various hues of green. Sudan IV stains of frozen sections revealed no lipoid material.

Spleen: The reticulum was widened by a deposit of pink-staining material compressing the sinusoids and reducing the malpighian corpuscles to small groups of lymphocytes. The deposit stained bright brown red with Congo red, but not with Sudan IV in frozen sections.

Liver: Many of the vessels except some central veins showed deposits as described.

Adrenal glands and pancreas: The vessel walls as well as the neurilemma of sympathetic nerve branches were the seat of amyloid deposit. There was increase in width of the zona glomerulosa of the adrenal without alteration of the character of the cells. Cells of the surrounding fatty tissue showed thickening of the cellular membrane by homogeneously pink-staining material which was identified as amyloid by a positive Congo red stain.

Kidneys: Amyloid deposit as seen in secondary amyloidosis was noted in the glomerular loops as well as in the wall of small vessels. These deposits reacted positively with Congo red.

Intestine and bladder: The vessels showed changes similar to those of the adrenal glands.

Skin: There was no evidence of amyloid change.

Brain and spinal cord: Some of the meningeal vessels were affected as described for lungs and liver, but the parenchyma was free of amyloid deposit. Amylaceous bodies were frequently noted and were particularly numerous in the parenchyma surrounding the third ventricle.

COMMENT

This case of amyloidosis presents many of the features which are characteristic of the primary form of the disease: (1) No specific etiological factor was present; (2) although amyloid deposits were present in spleen and kidneys, as is common with secondary amyloidosis, the deposit in the heart, sympathetic ganglia and blood vessels of the liver, pancreas, adrenal, intestine, bladder, and meninges is typical of the primary form; (3) staining reactions were atypical.

The most striking clinical feature was the degree of neuromuscular involvement. Unfortunately sections of skeletal muscle and peripheral nerves were not taken, but pronounced weakness, muscular atrophy and areflexia have been reported and explained on the basis of amyloid deposit in skeletal muscle or peripheral nerves.[2] The pupillary findings, early gastro-intestinal symptoms, and urinary retention may be due to involvement of the autonomic nervous system.

Of considerable interest in this case were the cardiovascular findings. The poor quality of the heart sounds, the low blood pressure, and, in part, the dyspnea and edema may be explained by the amyloid infiltration both in the myocardium and in the smaller cardiac vessels. The electrocardiographic pattern of low voltage and flattened T waves is considered to be typical and results from alteration of conduction through the abnormal myocardium.

Enlargement of the tongue associated with dysphagia and dysphonia, all of which were present in the case, are frequent findings in primary amyloidosis, due to infiltration of the tongue, buccal mucosa, larynx and trachea.[6-8]

Abdominal pain, simulating that of peptic ulcer, and constipation were prominent symptoms. Amyloid infiltration of the gastroenteric tract may account for such symptoms,[5] but was not found in this case. The symptoms may be explained on the basis of involvement of the autonomic nervous system.

Mild anemia, of a normochromic, normocytic type, was a feature in this case. Pathologically there was considerable fatty tissue in the bone marrow, and the blood vessels of the marrow did contain amyloid, but erythropoiesis within the small groups of bone marrow cells appeared normal.

Kidney involvement is more common in secondary amyloidosis, but has also been described in the primary form.[1, 4] As illustrated here, the laboratory findings are: albuminuria, casts, disturbance of power of concentration, lowering of the serum protein, reversal of the albumin-globulin ratio, and retention of the waste products of metabolism in the final stage.

SUMMARY

A case of primary amyloidosis is reported. Attention is called to the clinical symptoms of this disease entity with its involvement of the heart, spleen, kidneys, nerves, skeletal muscle, and blood vessels of most of the remaining organs of the body.

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Violent Reaction to Phenolphthalein

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A 34-YEAR-OLD man, an operator of a grain elevator, came under observation because of intermittent attacks of illness of a dismaying complexity which had begun some nine years before and had been occurring with growing frequency in the preceding two or three years.

Usually, all morning before a spell, the patient said, he would feel tense, nervous and apprehensive and would not care to eat because the stomach seemed oversensitive and full of gas. Then in the late afternoon he would be seized with a terrible and almost unbearable pain in the bones of one or both legs and would rush home and to bed. Usually a severe chill lasting for half an hour followed. By this time the pain in the legs, together with the feelings of tension and apprehension, usually had let up.

Ordinarily a rise in temperature to 103 or 104° F. ensued and this would last anywhere from five hours to three days. With the fever there might be frontal pain on one side or the other or clear across the forehead. There was no scotoma to suggest migraine and no stuffiness of the nose such as is seen with histaminic headache. There was no irritation of the bladder or swelling of joints, and never any nausea, vomiting, abdominal pain or diarrhea. There was no twitching, unconsciousness or delirium. Curiously, the third finger of the right hand got numb in the spells, suggesting irritation of a small cortical area.

In most of the attacks, as soon as the fever disappeared, the skin broke out with round, reddish, urticarial-like lesions about the size of a half dollar. This eruption, which was principally on the trunk and forearms, generally lasted about four days. In the first spells it faded entirely, but later it left brown smudges.

The patient was observed in one attack in which the skin lesions appeared without the pain and fever. In that instance the patient had a feeling of prickling all over the body.

The leukocyte count was 7,000 and the differential cell count was normal. The blood sedimentation rate was 11 mm. in one hour, Westergren.

Suggestive of a functional distress was the fact that the interval between attacks had been shortening. The patient had had two attacks in 1933 and three in 1940, while in 1941 he had had four within a period of three weeks. None of them had ever wakened him from sleep.

There had been no loss of weight.

Curiously, every year in June the patient felt tense and nervous and dopey, and fearful that an attack was coming.

The usual examination made by several internists threw no light on the problem. An allergic condition had been thought of and many skin tests had been made and diets tried out. There was no history of allergic reaction in the family and the patient did not have hay fever or asthma.

Somewhat in favor of a theory that the attacks might in some way be precipitated by something in the patient's industrial environment was the fact that he had not had one except in his home town, except for the recent spell in Rochester. The patient was sure, however, that the attacks were not associated with the handling of any particular grain. Much against a suspicion of allergic reaction to an item of food was the fact that months elapsed without an attack. Also against allergic reaction as a cause was the long duration of the fever.

Asked particularly about the use of drugs, the patient could not remember having taken any before an attack. Both the patient and his wife believed the attacks were of nervous origin and came when the strain of work let up. The attacks were never associated with any emotional crisis. In favor of the surmise that the symptoms might be of emotional origin was the fact that the patient was a rather repressed, lonely and very restless person who, as a boy, he said, would go to bed with a headache and fever whenever he lost his temper or had any psychic upset. He recalled that at such times he had been unable to eat for two or three days. Early in life he had had some symptoms suggesting migraine. His mother had had migraine. Always anger had made him ill, but it had never brought pain or fever or chills or urticaria. Puzzling and suggestive was the fact that his little daughter had a long history of curious episodes of high fever and semicoma, suggesting a migraine or epilepsy equivalent, or hysteria. An electroencephalogram of the patient was normal.

At the end of the diagnostic rope, the patient was referred to the dermatologic department of the clinic in the hope that the cause of the skin eruption could be recognized. Immediately, "phenolphthalein rash" was reported and, when a dose of the drug was given, pruritus and urticarial wheals developed in some of the pigmented areas. The attack was not typical of those the patient had had previously, but this may have been because he had just had a mild one which had "sprung the trap."

The patient still maintained that he was not taking any drug, but his physician recently wrote, saying that it is now established the cause of the trouble was a proprietary purgative, and there has been no recurrence since the use of the drug was stopped six years ago.

An interesting facet in this case was that the fever lasted for so long a time after the chill. In a case of pyramidon poisoning reported by the author, the fever curve was a high narrow spike.

SUMMARY

A highly sensitive man, after taking phenolphthalein, was seized with excruciating pain in the tibias, followed by severe chill, temperature of 103 to 104° F. and an urticarial rash that left brown smudges, especially on the trunk and forearm.

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California Cancer Commission Studies*

Chapter XXX

Bone Tumors

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BONE tumors occur so uncommonly that in general practice they must be rare indeed. Because of this most physicians are not likely to become familiar with them, and hence correct diagnosis is often long delayed. The malignant tumors (sarcomata) metastasize early and any delay will inevitably prove fatal. Early recognition therefore is absolutely essential.

BENIGN BONE TUMORS

The most common benign bone tumor is the osteochondroma, a smooth-surfaced, cartilage-covered pedicled mass attached to the cortical surface of a long bone near the epiphyseal line. This painless benign tumor is easily recognized in an x-ray film, biopsy not being necessary for the diagnosis. It is most often seen in children (Figure 1, left) but is not rare in adults. Osteochondromata should be removed as they may become so large that they impinge upon nerves or blood vessels (Figure 1, center and right).

Giant cell tumor (Figure 2), solitary bone cyst (Figure 3, left) and enchondroma (Figure 3, right) are three benign tumors whose x-ray appearance, symptoms of onset and treatment have certain common characteristics. The x-ray reveals bone destruction and distention with preservation of a thin cortical layer encompassing the neoplastic mass. The tumor itself is divided by thin osseous walls into many cells of various sizes, the "soap bubble" appearance. The tumor is often asymptomatic so the patient is quite ignorant of its presence until a pathological fracture occurs. X-ray films are then made, a tumor is recognized and therapy instituted. The best treatment in most instances is thorough curettage followed by firm packing of the cavity with bone chips. Material removed permits the pathologist to establish a positive diagnosis. A final common peculiarity is the slight tendency (less than 10 per cent) for these tumors to recur, requiring a second, and rarely a third operation.

Osteoid osteoma (Figure 4) is a rare benign bone tumor, seen most often in children, affecting the cortex or subcortical area of a long bone. Aching pain is the predominant symptom. Cure is easily effected by surgical removal of the nucleus or nidus visible in the x-ray film at the center of the thickened area.

MALIGNANT BONE TUMORS

For the practical purposes of this short presentation malignant tumors arising in bone (Figures 5 and 6) can all be considered together. They have a tendency to occur in children and cause pain. They metastasize early (lungs), but in spite of this cure is not impossible. There are many ten- and fifteen-

*Organized by the Editorial Committee of the California Cancer Commission.

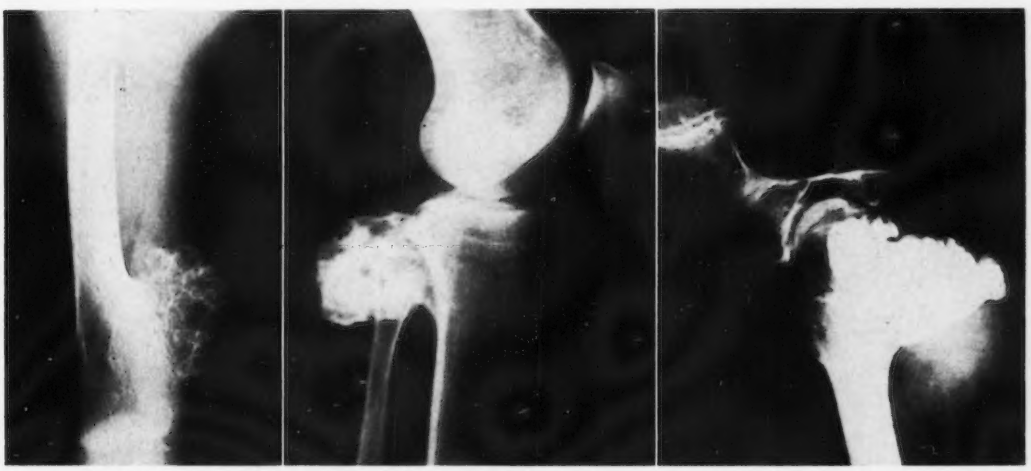

Figure 1. (*Left*)—Typical benign osteochondroma, femur (male age 14). Note pedicle attached to cortex. The cauliflower-like osseous medulla is covered with a smooth-surfaced but lobulated cortex of cartilage.

(*Center*)—Benign osteochondroma, posterior surface, epiphysis of tibia (male 35) present many years. Thrombosis of popliteal artery with impending gangrene of foot brought patient to clinic.

(*Right*)—Benign osteochondroma, posterior surface, neck of femur in woman age 45. Pressure on trunk of sciatic nerve, especially on sitting, causing severe neuralgic pains, eventually "drove" patient to consult a physician.

year cures on record. There will be many more such cures if these tumors are recognized early.

Recognition: Little acumen is required to recognize the far advanced and commonly described case —the patient, an anemic, emaciated child with a visible and palpable bone tumor over which the stretched skin is excessively warm and contains dilated blood vessels. But, if we are to save patients, malignant bone tumors must be recognized long before this stage is reached. Any person, but particularly a child, who continues to complain of aching pain in a bone should have x-ray examinations every two weeks until the cause of the pain is found. The films must be of good quality so that the finer anatomy of the osseous architecture can be carefully compared with x-ray films of the normal side. The films must be taken in several planes and must include the joint above and below the site of pain. Unfortunately, clinical examination gives little, if any, information at the time when it is important to make the diagnosis. Tenderness to prolonged pressure should arouse suspicion. Wassermann reaction, sedimentation rate, blood counts and other laboratory work are, of course, important, but in the final analysis it is the x-ray appearance of periostitis, areas of diminished or increased density or

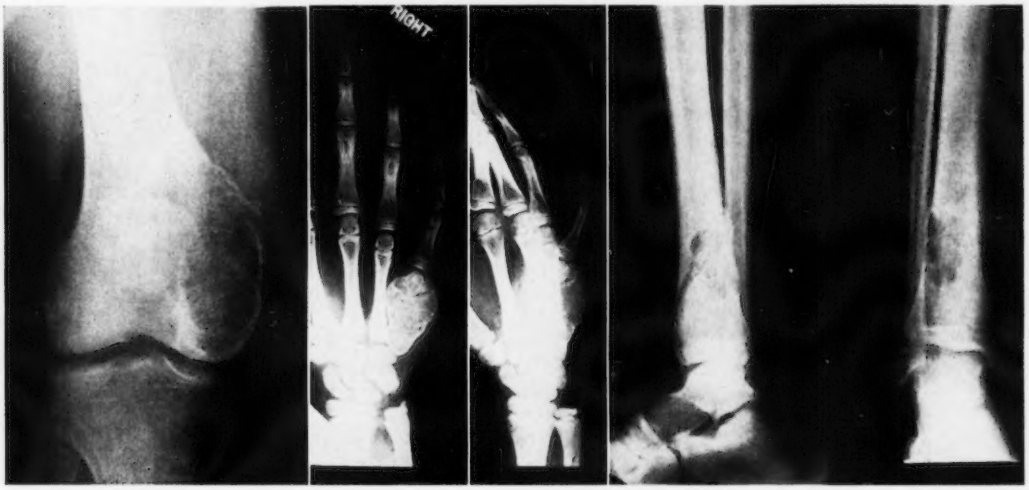

Figure 2. (*Left*)—Common picture of giant cell tumor. Important characteristics to be noted: Adult, located in epiphysis; expansile lesion; marked destruction of bone but thin layer of cortex preserved over surface; no new bone formation; tumor closely approaches but does not penetrate the articular cartilage; pathological fracture through thin cortex.

(*Center*)—Very large expansile benign tumor involving entire fifth metacarpal in patient 6 years of age. X-ray diagnosis: cyst or enchondroma. Pathological diagnosis: typical giant cell tumor.

(*Right*)—Pathological fracture through giant cell tumor diagnosed by x-ray as bone cyst since (1) patient aged 12 (2) the lesion appeared in shaft. Pathological picture typical of giant cell tumor.

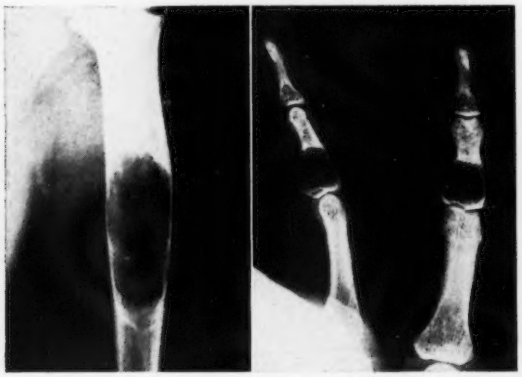

Figure 3. (*Left*)—Common picture of a solitary bone cyst in a child 9 years of age. Important characteristics to be noted: Child, lesion located in metaphysis; expansile lesion; marked destruction of bone but thin layer of cortex preserved over surface; no new bone formation.

(*Right*)—Common picture of an enchondroma in a patient aged 30. Note: Expansile lesion, shaft of phalanx; adult, lesion located in shaft of short bone; marked destruction bone but thin cortex preserved over surface.

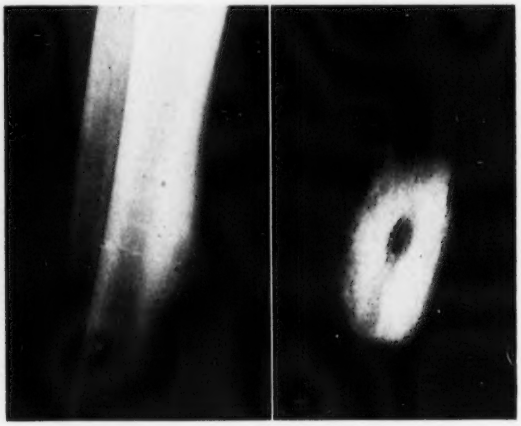

Figure 4. (*Left*)—Lateral view tibia patient aged 12. Note smooth surfaced thickening of cortex with small localized oval area of decreased density in center (nidus).

(*Right*)—X-ray of portion removed at operation showing central nidus.

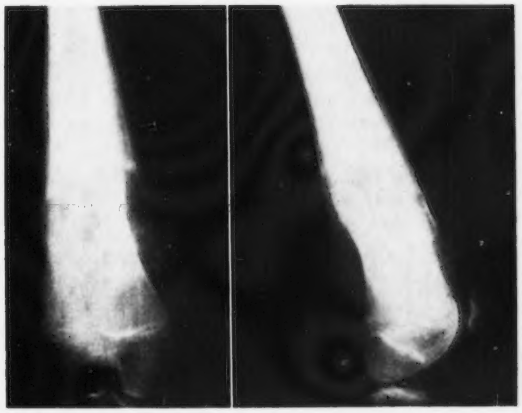

Figure 5.—Sarcoma, femur (osteogenic type) in a patient aged 14. Positive diagnosis by biopsy followed immediately by amputation at hip. Patient well 13 years later. Note: Periostitis in layers extending up shaft; location near epiphyseal line; spicules (whiskers) of new formed bone at right angles to shaft; areas bone destruction within cancellous area of metaphysis; areas of increased density; tumor extends to but does not penetrate epiphyseal plate.

new bone formation which arouses suspicion of malignancy. At this point the case immediately becomes an emergency and the patient must be hospitalized under the care of a surgeon and pathologist who have had experience in diagnosis and definitive care of malignant bone tumors.

BIOPSY

Although the x-ray picture may be "typical" of bone sarcoma the fact remains that accurate diagnosis can be made only by an expert pathologist. This requires biopsy, which should be done in the presence of the pathologist, who shares the responsibility of selecting proper material. Many times by studying frozen sections he can be absolutely certain of the diagnosis and allow the surgeon to go ahead with radical amputation. In rare cases, however, he will need to study paraffin sections. In these cases treatment, unfortunately, must be delayed 24 hours. This is the only acceptable excuse for any delay whatsoever between biopsy and definitive treatment. The all too common practice of giving a six-week

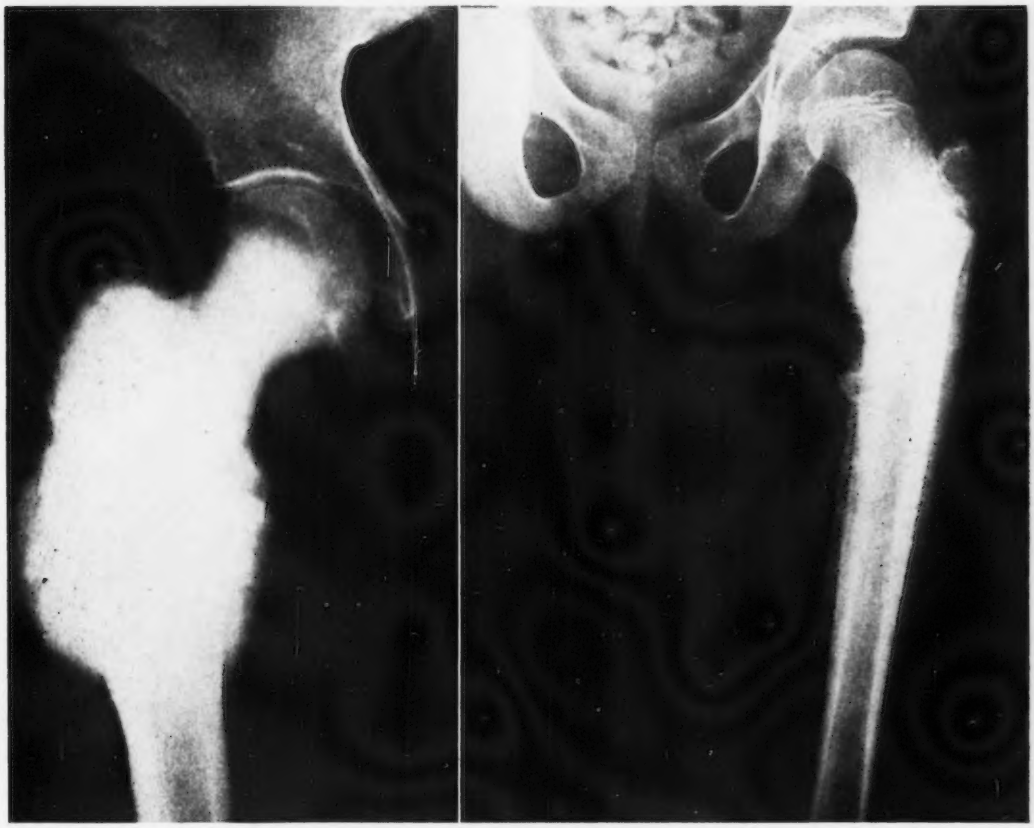

Figure 6. (*Left*)—Sarcoma of the femur (osteoblastic type) in a patient 40 years of age. Positive diagnosis by biopsy. Patient refused amputation and died in six months of pulmonary metastases. Note marked sclerosis of bone with much newly formed bone; no destruction.

(*Right*)—Sarcoma of the femur (Ewing's type) in a 10-year-old patient. Note extensive new bone formation and architectural changes. At onset of trouble patient had fever with pain. A diagnosis of osteomyelitis was made and the femur was drilled. No biopsy was taken at that time. Biopsy later revealed typical Ewing's sarcoma. This tumor is sometimes mistaken for osteomyelitis because of the common occurrence of fever in the early stages of the disease. X-ray therapy gave this child temporary relief, but she died later of cerebral metastases.

test of x-ray therapy or of taking a biopsy specimen, closing the wound and "sending the material to the city" for pathological examination cannot be too strongly condemned. The biopsy should be done with two tourniquets on the affected limb and the biopsy wound should not be packed but carefully sutured.

TREATMENT

The treatment of malignant bone tumors is amputation. On rare occasions wide excision of the tumor and surrounding structures is justifiable. Palliative x-ray therapy is helpful in certain tumors.

SUMMARY

Early recognition of the malignant tumors primary in bone offers the only hope for cure. Therefore the physician must have expert and adequate x-ray studies made in all patients with persistent bone pain.

Positive diagnosis can be made only by an expert pathologist. This necessitates biopsy and frozen section.

Any delay between the time suspicion of malignant tumor is aroused and biopsy is inexcusable.

California MEDICINE

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EDITORIALS

Physicians for the Armed Forces

Again the armed forces are calling for medical officers, and the need is urgent. The Army, the Navy and the Air Force, each has its own recruitment objective; each is short of medical officers to care for the augmented personnel under the country's present military program.

Physicians have shown great reluctance to offer their services to the armed forces, many of them doubtless because of reports of wasted effort and inefficiency prevailing during the war years. Some of these reports were undoubtedly true and some of the instances were probably inexcusable. On the other hand, the demands of a shooting war call for the standing-by of many specialty groups of officers, pending their call to emergency service when and where the need arises. Medical officers were, by and large, pretty well insulated from the problems of tactics and logistics confronting field commanders; in the circumstances it is easy to see how many doctors could arrive at conclusions which would lead to disparagement of the way of life of medical officers in the armed forces.

Today the country is at peace. The armed forces are better stabilized, each branch with its own program of utilization of personnel and each in position to assign specialists where they are actually needed. In addition, the armed forces have acted vigorously to overcome their own admitted shortcomings in attracting professional personnel. Postgraduate and study opportunities have been vastly enlarged and improved. Consultation with leading civilian specialists has been arranged on a scale and in a manner to permit the young medical officers to rub shoulders with leading medical specialists and to absorb knowledge from them. Clinical opportunities have been augmented and paper work has largely been relegated to trained ancillary personnel.

On top of that, pay scales and allowances have been made more attractive. And wartime living conditions have been supplanted by peacetime improvements which offer the medical officer and his family a chance to live decently, in good company.

When Congress was setting up the present draft law a couple of years ago, the original bill called for authority to conscript medical and other professional officers up to the age of 45 years. Medical associations throughout the country resented this provision as a slur on the splendid record of patriotism which had caused the profession to oversubscribe its personnel quota whenever the country had gone to war. The Congress took out that provision, relying on the profession to meet the demands for medical officers in the peacetime services. At the same time, a number of physicians who had been trained at federal expense under the V-12 or ASTP programs were available for two-year tours of duty in accordance with their educational agreements.

Today we find that these young doctors are finishing their tours of duty and are turning to private practice at the earliest opportunity. We also find that many young doctors who were deferred from wartime military service because they were in medical school at their own expense are reluctant to offer their services.

Medicine owes a debt to the armed forces for the manner in which the profession was treated during the war years. Many physicians owe personal debts to the armed forces, either for furnishing their medical education or for deferring them from active service because they were engaged in securing a medical training at their own expense. Some of these physicians have volunteered their services; many have not.

The California Medical Association has officially notified the armed forces of its desire to cooperate in the procurement of needed medical officers. The Association realizes that throughout the state there are a number of physicians who have a moral, if not a legal, obligation to the armed forces and who have not yet come forward to stand their turn in the line of duty. The county medical societies have been asked to help locate such physicians and to urge them to come front and center. This request is here reiterated, with the greatest urgency. The alternative: Conscription of doctors up to the age of 45 years, which might entail the drafting of many men who have already earned the right to private practice by having given of themselves patriotically during the 1941-1946 period.

The county medical societies may well wish to ask their available colleagues if it isn't better, here as in sickness cost insurance, to solve this problem in the voluntary, not the compulsory, way.

Medicine and Animals

Again in 1949, even as in 1948, in 1947 and in years before, antivivisection legislation has been appearing before our state legislatures. And again, even as in earlier years, a campaign of babies versus dogs has eventuated.

Doctors are getting a little fed up with this sort of legislative legerdemain, a little tired of having to justify their laboratory work in terms of emotionalism. Particularly are they tired of having to pull out some of the emotional stops instead of sticking close to their scientific sphere. On the other hand, they recognize the processes of democracy at work in such legislative attempts.

Our system of government is based on the right of the people to petition for change. Their petitions may be well or ill founded; they may be accepted or rejected. Regardless of origin, such petitions are granted the right of full hearing, full discussion, full consideration, before any final decision is reached. People who would sponsor legislation for antivivisection, or for any of a variety of subjects which might run the gamut from the facetious to the paranoic, still have the right to make their views and wishes known, provided only that they are able to find a member of a legislative body who is willing to introduce a bill which would carry out their proposals.

In 1949, as in years past, we have seen another rash of antivivisection bills brought forth, in our own state as well as in sister sovereignties. We have also seen the introduction of measures which would place a legitimate restraint on the use of animals in experimentation by providing for the inspection and licensure of premises and institutions where such experimentation would take place. Bills of this character are designed to put a stop to any possible illicit use of animals in unsupervised and unregulated experiments while, at the same time, they provide an official and publicly-regulated supervision of all premises and auspices which would seek to employ animals in their scientific march.

It is a sad commentary on the followers of the antivivisection cult that they are not content to permit legislative passage of such measures. Such bills actually would purely serve the antivivisectionist cause—the prevention of illicit and medically-opposed experimentation not based on science and possibly containing elements of sadism in unorthodox individuals. Nevertheless, some of these cultists carry on to great lengths in voicing their opposition to even this type of legislation.

A recent report from the nation's capital told of the packing of a hearing room in Congress with antivivisectionist followers who openly cried and wailed over a proposal for the release of doomed pound animals to approved research institutions. These so-called animal lovers were horrified by a request that the pound animals, strays which were picked up and held in public custody because their former owners were not enough interested in them to seek their whereabouts, be turned over to laboratories for scientific purposes rather than put to death in the functioning of health laws.

All in all, 1949 looks like another year of stalemate in the realm of animal experimentation. Dog and cat lovers voice their pleas; scientists ask that animals slated for the gas chamber be made available for humanely governed experiment for the advancement of scientific medicine. Neither side seems to be gaining much headway and neither seems discountable for future years and future legislative sessions. It looks as though dogs versus babies will be with us for a long time to come.

CALIFORNIA MEDICAL ASSOCIATION

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ED CLANCY, Field Secretary.....Southern California Office, 417 South Hill Street, Los Angeles 13

NOTICES AND REPORTS

C.M.A. House of Delegates Proceedings

May 8, 1949

The first meeting of the House of Delegates of the California Medical Association convened in the Music Room of the Biltmore Hotel, Los Angeles, California, Sunday, May 8, 1949. The Speaker, Dr. Lewis A. Alesen, of Los Angeles, California, called the meeting to order at 5:00 p.m., and presided.

SPEAKER ALESEN: Will the meeting please come to order.

The Chair will recognize Dr. Carl Hadley of San Bernardino, chairman of the Committee on Credentials.

Dr. Hadley, will you give your report to the House at this time.

DR. HADLEY: Mr. Chairman, the Committee on Credentials wishes to report we have registered a sufficient number for a quorum.

SPEAKER ALESEN: A motion is in order to accept the report of the Committee on Credentials as constituting the roll call for this meeting.

A MEMBER: I so move.

A MEMBER: Second.

The motion was put to a vote and was unanimously carried.

SPEAKER ALESEN: I now state this House is duly constituted.

At this time the Chair wishes to make the announcements of the Reference Committees appointed in accordance with the By-Laws.

Committee on Credentials: Carl M. Hadley of San Bernardino, chairman; Stanley R. Parkinson of Yuba County, Frank G. Crandall of Los Angeles.

Reference Committee No. 1:

Reference Committee on the Reports of Officers, the Council and Standing and Special Committees: Eric Royston of Los Angeles, chairman; Ivan C. Heron of San Francisco; Burt Davis of Santa Clara.

Reference Committee No. 2:

This is the new committee or a rearrangement of the old Committee No. 2 to handle the financial matters. Committee on Finance to review the reports of the Secretary-Treasurer and the Executive Secretary and to study and make recommendations to the House of Delegates on the budget submitted by the Council and the amount of dues for the ensuing year: Alson R. Kilgore of San Francisco, chairman; Stanley R. Truman of Alameda County, and G. Wendell Olson of Orange County.

Reference Committee No. 3:

Reference Committee on Resolutions, Amendments to the Constitution and By-Laws and New and Miscellaneous Business: Francis E. Jacobs of San Diego, chairman, and M. Laurence Montgomery of San Francisco.

Reference Committee No. 4:

This is a new committee this year—Reference Committee on Executive Session. J. Norman O'Neill of Los Angeles, chairman; A. A. Morrison of Ventura County and Dave F. Dozier of Sacramento County.

If I hear no objection from the members of the House, these committees will have your approval.

At this time, ladies and gentlemen of the House of Delegates, it is my pleasure to present to you our President, Dr. E. Vincent Askey, who will give us an address. Dr. Askey. (Applause.)

DR. ASKEY: Mr. Speaker, members of the House of Delegates: My address will be very short because I know you have a lot of work to do. I merely want to express to you my appreciation in a personal way for the support that each and every one of you has given to me during the year which has been rather full of effort and full of many things we had to do. But it has been a pleasure to me to know that I have had your wholehearted support and I have not asked of you a single thing that you haven't done with the fullest cooperation.

I want you to know that I appreciate it from the depth of my heart and I thank you for the honor that you have given me.

And with that my address consists of 2210 West Third Street. Thank you. (Applause.)

SPEAKER ALESEN: It says here in the printed agenda, "Miscellaneous announcements by the Speaker." Mr. Hunton wants to call your attention to the fact there will be available in Room 2341 stenographic service between the hours of 6:00 and 7:15 during our recess. Stenographic help may be given you in the preparation of the resolutions which can later be presented to the House this evening.

Your attention is called to the fact that all resolutions must be presented immediately in triplicate in order to conform with the provisions of the By-Laws. Also, will the chairmen of the Reference Committees please be prepared at the end of this meeting to announce the time and place of meeting of their respective committees in order that members of the House of Delegates who wish to appear before these committees may be so informed.

At this time we will have the report of the Council. In the absence of Chairman Edwin L. Bruck, Dr. Sidney Shipman will give the report of the Council. Dr. Shipman.

REPORT OF THE COUNCIL

DR. SIDNEY J. SHIPMAN: Mr. Speaker, members of the House, there is no further report except as follows: The Council met yesterday and this morning as required by the Constitution and By-Laws. It will submit the budget to the proper committee and has made the recommendation that the dues be reduced. We thought that would meet with your approval. (Applause.)

Following is the proposed program of the California Medical Association for the improvement of medical care, which also was passed. It was thought advisable that we should have a set of principles similar to the principles which were enunciated by the A.M.A., and a request has been made for such principles to be recommended by the California Medical Association.

The following are proposed:

1. *Health Insurance.* Further development and wider coverage by voluntary medical care and hospital plans (both medical association and insurance company sponsored) to meet the costs of illness. Aid to the indigent by the utilization of these plans by the several counties, with local administration and determination of needs.

2. *Public Health.* Coordination and integration of all public health activities, except those of the medical services of the armed forces, under the State Department of Public Health. Incorporation in local public health units of such services as communicable disease control, vital statistics, environmental sanitation, control of venereal diseases, maternal and child hygiene and public health communicable disease laboratory services.

3. *Rural Care.* Encouragement of the development by professional and lay organizations of medical and hospital services for rural areas, and of the integration of those services with regional county hospitals and small institutions.

4. *Mental Hygiene.* Continued development of the state program of mental hygiene.

5. *Chronic Diseases and the Aged.* Aid by the voluntary and state welfare agencies, combined with professional and other services, in the provision of care and rehabilitation of the aged, and those with chronic disease, and various other groups not covered by existing arrangements.

6. *Industrial and Preventive Medicine.* Greater emphasis on the program of industrial medicine, with increased safeguards against industrial hazards and prevention of accidents occurring on the highway, in the home and on the farm.

7. *Veterans' Medical Care.* Integration of veterans' medical care and hospital facilities with other medical care and hospital programs and with the maintenance of high standards of medical care, including care of the veteran in his own community by a physician of his choice.

8. *Health Education.* Health education programs administered through suitable local educational, health and medical agencies to inform the people of available facilities, and of their own responsibilities in health care.

9. *Medical Education and Personnel.* Promotion of private financial assistance to medical, dental and nursing schools and other institutions necessary for the training of specialized personnel required in the provision and distribution of medical care. Revision of income tax and estate tax laws so as to encourage people to donate needed assistance to medical and associated professional education.

10. *Medical Research.* Continued promotion of medical research through private grants to institutions equipped and staffed to carry on qualified research.

That is the proposed program of the California Medical Association for the improvement of medical care. Thank you. (Applause.)

SPEAKER ALESEN: One addition to this report has been made: "No. 11, *Postgraduate Education.* Expansion of the postgraduate training program of the California Medical Association to assist practitioners in rural areas in keeping abreast of the latest advances in medicine."

This report of the Council with the addenda thereto will be referred to Committee No. 1.

Next is the report of the Trustees of the California Medical Association. E. Vincent Askey, is there anything to report?

PRESIDENT ASKEY: Mr. Speaker, no further report.

SPEAKER ALESEN: That report will be referred to the Reference Committee on Finance.

Report of the Auditing Committee. Dr. Sidney J. Shipman.

DR. SHIPMAN: No further report.

SPEAKER ALESEN: That report will be referred to Committee No. 2, inasmuch as that committee has to do with considering dues and financial aspects.

Report of the Secretary, Dr. L. Henry Garland.

DR. GARLAND: Mr. Speaker, nothing to report.

SPEAKER ALESEN: That will be referred to Committee No. 2.

Report of the Executive Secretary, Mr. Hunton.

SECRETARY HUNTON: Mr. Speaker, nothing to report.

SPEAKER ALESEN: That will be referred to Committee No. 2.

Now, the report of the Editor, Dr. Dwight L. Wilbur.

EDITOR WILBUR: No additional report, Mr. Speaker.

SPEAKER ALESEN: It will be referred to Committee No. 1.

Reports of District Councilors. Do any of the District Councilors wish to add to the reports as they have been printed in the Annual Reports Bulletin? We shall not call them out by name. If any one of the Councilors so wishes, will he please so state?

(No response.)

Report of the Councilors-at-Large. Is there anything to be added in this report?

(No response.)

Report of Legal Counsel. Mr. Hassard, do you have anything additional to give us at this time?

(No response.)

If not, the reports will stand as printed in the Annual Reports Bulletin and will be referred to Committee No. 1.

Now, the Standing Committees. The Executive Committee. Dr. Sidney J. Shipman, do you have anything further to add?

DR. SHIPMAN: No addition.

SPEAKER ALESEN: Referred to Committee No. 1.

Committee on Associated Societies and Technical Groups, Dr. Robert A. Scarborough.

DR. ROBERT A. SCARBOROUGH: No additional report.

SPEAKER ALESEN: Referred to Committee No. 1.

Committee on Health and Public Instruction, Dr. Orrin Cook.

DR. COOK: No further report.

SPEAKER ALESEN: It will be referred to Committee No. 1.

Committee on History and Obituaries, Dr. Morton R. Gibbons, Sr. Have you any additional report, Dr. Gibbons?

If not, it will be referred to Committee No. 1.

Committee on Hospitals, Dispensaries, and Clinics, Dr. Carroll B. Andrews. Is there any further report, Dr. Andrews? Committee No. 1.

Committee on Industrial Practice, Dr. Donald Cass.

DR. CASS: No further report.

SPEAKER ALESEN: Committee No. 1.

Committee on Medical Defense, Dr. Nelson Howard.

DR. HOWARD: No further report.

SPEAKER ALESEN: Committee No. 1.

Committee on Medical Economics, Dr. H. Gordon MacLean.

DR. MACLEAN: No further report.

SPEAKER ALESEN: Committee No. 1.

Committee on Medical Education and Medical Institutions, Dr. L. R. Chandler.

DR. CHANDLER: No additional report.

SPEAKER ALESEN: Committee No. 1.

Committee on Organization and Membership, Dr. Carl L. Mulfinger. Have you any additional report?

(No response.)

If not, Committee No. 1.

Committee on Postgraduate Activities, Dr. John C. Ruddock. I know Dr. Ruddock has a special report he wishes to make. The Chair will recognize him at this time.

REPORT OF COMMITTEE ON POSTGRADUATE ACTIVITIES

DR. JOHN C. RUDDOCK: Mr. Speaker and members of the House of Delegates: During the past year, your committee has met on a number of occasions, concerning postgraduate activities for the membership of the California Medical Association.

Your committee wishes to thank the Council of the California Medical Association for its cooperation and understanding of the problem in California, and for making available funds, clerical help and office space, in order to carry on this project.

The problem is not an easy one. Simply stated, its purpose is to give an opportunity to members of the California Medical Association, and especially to those members who are practicing in the areas not immediately adjacent to teaching centers, an opportunity to advance themselves in the practice of medicine and its specialties, by postgraduate study. Your committee was faced immediately with numerous proposals concerning the methods by which postgraduate facilities could be made available to our membership.

Before adopting any policies we sent Dr. Andrews, our Director, to other states that had an established program in operation. In particular, we surveyed the plans of New York, Pennsylvania, Michigan, Tennessee and Oklahoma.

In addition, various plans, as adopted by various universities for postgraduate study, were reviewed. None of these plans could be applied to California as a whole. This state is large, distances are great, there are large metropolitan areas and sparsely settled rural areas. There are four large high class medical schools, each with its own postgraduate departments. In addition, operating on separate budgets and independently, conducting postgraduate programs, are a well-established public health department as part of the state government of California, the California Tuberculosis and Welfare De-

partment, the Cancer Commission, and the California Heart Association.

The problem affected primarily those doctors who were not adjacent to the four major universities, situated in San Francisco and Los Angeles.

There are approximately 4,000 members of the California Medical Association who should be considered as non-metropolitan doctors.

Early, your committee realized that a survey of these non-metropolitan members would elicit 4,000 separate programs of postgraduate education. It then became necessary for your committee to decide what the doctors needed and to make it available for them, attempting when possible to accede to the wishes of the majority.

After much study your committee has adopted the following policies:

The California Medical Association shall not attempt to set up, organize, or run a postgraduate school.

Two, the Committee on Postgraduate Activities shall act as a liaison between the medical schools and other organizations and departments and keep the membership advised of postgraduate activities available throughout the year, within the State of California.

Three, the Committee on Postgraduate Activities will arrange postgraduate seminars at selected centers within the state which are easily accessible to most of the 4,000 non-metropolitan members. These conferences will consist of didactic lectures and clinical demonstrations. An honorarium will be paid the speakers or instructors. Traveling expenses and other miscellaneous costs will be absorbed by the association.

Four, the Committee on Postgraduate Activities will assist universities and all other departments and organizations in arranging dates and places of meetings to avoid conflict and duplication, and in any other manner will encourage postgraduate opportunities for the members of the California Medical Association.

Five, the Committee on Postgraduate Activities will not attempt to give under its sponsorship any courses for certification in a specialty.

Six, except for the publication of opportunities for resident and intern training, the Committee on Postgraduate Activities will not concern itself with this type of training.

With the adoption of the above policies, Dr. Carroll B. Andrews was engaged as Director of Postgraduate Activities. He gives the association one-half of his time at a salary of $6,000 per year. Dr. Andrews has ably and excellently fulfilled the duties of this position.

Since March 1, 1948, thirteen postgraduate seminars have been held under his direction as follows: San Luis Obispo, Marysville, Redding, Santa Barbara, Riverside, Monterey, Modesto, San Diego, San Bernardino and Fresno. There have been two conferences held on separate dates at El Centro and Santa Rosa.

The total attendances at these meetings has been 733, varying from 16 to 109. The total cost of the 13 seminars was $4,618.98, and the cost per person attending amounts to $6.30.

When we add the salary of the director your committee has spent a total of $10,618.98, or a cost per person attending of $14.48. The cost per seminar amounts to $816.84. A detailed statement of expenses is appended. With the experience of the past year your committee wishes to make the following proposals:

1. That the Council of the California Medical Association be directed to continue the allocation of funds for carrying on the policies as adopted by your committee, and to make available to the members, and especially the non-metropolitan members of the California Medical Association, postgraduate opportunities.

2. That an office assistant to the Director of Postgraduate Activities be engaged full time as soon as practicable and that adequate office space be made available so that the Director will be free for the field.

3. That an Advisory Committee be appointed to meet with the Standing Committee at least once yearly, in order to implement and arrange the programs and type of instruction to be given in the various localities about the state. It is proposed that this committee be composed of the following: (a) One representative from each of these medical schools, University of California, Stanford, University of Southern California, U.C.L.A. and Medical Evangelist; (b) one representative from the Cancer Commission, Public Health Department, California Tuberculosis Association, and California Heart Association; (c) a surgeon, an internist, a pediatrician, a general practitioner, and an obstetrician selected at large.

4. That the expenses of these 14 members attending the Advisory Sub-Committee meetings with your committee shall be absorbed by the California Medical Association.

5. That the California Medical Association continue its membership in the National Postgraduate Association of the A.M.A. and that a representative of the Postgraduate Committee be selected to attend that group's yearly meeting and such other meetings as are considered necessary and advisable by the committee and Council of the C.M.A.

6. That the Postgraduate Committee cause to be published in each issue of CALIFORNIA MEDICINE all postgraduate programs and opportunities fostered by the universities and other organizations available within the state.

7. That the Postgraduate Committee encourage and assist the various county medical associations and their committees in order to foster postgraduate studies at the county and local levels.

Respectfully submitted, Committee on Postgraduate Activities, John C. Ruddock, chairman. (Applause.)

SPEAKER ALESEN: Thank you, Doctor. This report will be referred to the Reference Committee No. 1.

Committee on Publications, Dr. George Dawson.

DR. DAWSON: No further report.

SPEAKER ALESEN: Committee No. 1.

Committee on Public Policy and Legislation, Dr. Dwight H. Murray. Is Dr. Murray here?

DR. MURRAY: Yes.

SPEAKER ALESEN: You know, ladies and gentlemen of the House, I am no expert at gilding the lily. But I would like, in introducing this man, to call your attention to the excellent work he has done and is doing on behalf of organized medicine.

It is a pleasure to present our chairman of the Committee on Public Policy and Legislation, as well as Trustee of the American Medical Association, as well as the holder of many other offices. Dr. Dwight Murray of Napa. (Applause.)

REPORT OF COMMITTEE ON PUBLIC POLICY AND LEGISLATION

DR. DWIGHT H. MURRAY: Mr. Speaker, members of the House of Delegates: I am very glad to report to you some of the results of the work of the Legislative Committee. Some of our work has not been so successful as we would like to have had it, but nevertheless I shall report it to you as is.

As you have heard, there were something over 5,000 bills introduced into the Legislature at Sacramento, something a little bit less than 500 having to do with medical care and public health. It has been difficult to keep track of all those bills. Any and all of those bills are subject to amendment at any time and what may look like a good bill one minute can be amended so it is a bad bill the next.

I want to make perfectly clear that your Legislative Committee does not in itself decide whether it will support or oppose a measure. That we do at the direction of the Council. Only in cases of amendment or in cases where immediate action is necessary does the Legislative Committee take the decision unto itself.

I wish you to keep in mind that before the next meeting of the House of Delegates, we will have an election campaign under way. I ask that you talk to the men who are candidates to determine that they think rightly about compulsory health insurance.

I would like to make this a recommendation to the delegates: In talking to your prospective candidates that you ask them to discuss with you, if possible, any bill that might pertain to legislation in any way affecting the practice of medicine, before they endorse that bill or before they become an author of the bill.

Now, many times legislators will put their name on a bill as author or co-author, without particularly knowing what is in the bill. And if you can discuss it with them or if you will ask the legislators if they will talk with you and get your advice and suggestions before they sponsor a bill, we will go a long way toward solving and correcting some of the evils that exist at the present time.

After all of these bills are analyzed, then comes the problem of properly disposing of them, and in the proper way.

We have had an unfortunate experience this year that we haven't had in years past. Your Legislative Committee spent a great deal of time in analyzing all the bills introduced. We had our Legal Department assist us in this. The Councilors themselves were called upon. The Chairman of the Council, Chairman of the Executive Committee of the Council, and different members of the Council were asked to help us in analyzing these bills to determine which should be opposed and which supported.

Finally, after a meeting—an all-day meeting, I should say, and then some—of the Council in San Francisco early in March, it was decided on which bills we would support and which we would oppose.

That list was made up and was sent out to the presidents, the secretaries of the component county societies, and to the various key men through the various counties, so there would be no question in anybody's mind about what bills we would oppose and which ones we would support.

We thought that would guide them properly. This was all done at the direction of the Council and not at the direction of the Legislative Committee.

However, one county society decided that it would take the matter into its own hands and its own legislative committee would go over the bills and would do as it saw fit about some of the bills.

One of the bills we were particularly interested in. We wanted to oppose the bill. The county society looked over the bill and thought there was no reason to oppose it. They so notified their senator, with the result we lost the bill in committee.

Now, gentlemen, any local society, I think, may look at legislation from somewhat of a local point of view rather than an over-all point of view, which the Council is able to do, and you can readily understand that that plays some havoc with your Legislative Committee. I trust that shall not recur.

Now, as to the particular bills that we have had.

It is always necessary to go over the Medical Practice Act. You understand that our Medical Practice Act changes from day to day. That is, the need for changing it, I should say. Oftentimes this Medical Practice Act would seem to be all right. It may be all right in 1947, and might not be all right in 1949.

So there was an interim committee of the Senate, headed by Senator Hugh M. Burns of Fresno, who studied this problem, and the committee introduced some 14 bills of its own, to change the Medical Practice Act, to tighten it here and loosen it there, and so on.

Most of these bills have passed or are in the process of being passed.

In addition, the Board of Medical Examiners sponsored some bills they wished to be considered,

and they have all been considered on the whole favorably, and the ones that have not been acted on favorably, I think, will be before the session is over.

Now, one of our old bills that we have had before us a long time is the anti-vivisection bill. I graduated from medical school a great many years ago, which you all know, and I remember at that time anti-vivisection was considered, and I think it has been considered in every session of the California Legislature for the last 20 years, at least.

The deans of our medical schools, two years ago after appearing in Sacramento to oppose a very obnoxious bill, decided they would draw up a bill of their own, and they established a committee to work on that.

They studied it not only from the California point of view, but from the point of view of the other states, New York, Massachusetts, Illinois, and a great many other states, in order that they might be able to draw a bill that would be right.

They spent a lot of time on it, and the result of their efforts was shown, and the deans of all medical schools and representatives of all medical schools came to Sacramento and stayed overnight and helped us with these bills.

I will tell you it was a grand feeling to have, to be able to say, as I did, to the members of the committee, "You now have the top-flight medical men of the State of California. If you have any questions you want to ask, or any information you want to get, here is the place to get it."

The bill was presented in a very, very nice way, and the bill went to committee, I am hoping without a single objection in any way, and went out with the recommendation to pass.

Now, that bill means that all laboratories dealing with experimental animals will be under the direction and licensing of the Department of Public Health, and that the Department shall inspect and they shall ask and advise and seek changes that are necessary and correct any evils that exist.

That satisfies a great many of the people who have been opposing this. Of course, there are many of the good-doers and die-harders that you will never satisfy.

Probably the worst bill we have to oppose, the most difficult one, is that pertaining to compulsory hospital insurance. That was tacked onto a bill of disability insurance.

There are about 30 bills introduced having to do with disability insurance, one way or the other. This bill would have been very definitely the entering wedge for compulsory insurance in California. That bill was opposed very vigorously and the doctors of the state responded beautifully when we asked them to come to Sacramento.

They came in twos to Sacramento and stayed overnight. They spent the day. They spent the night with their Senators telling them what they thought of the bill and what they thought it would mean and why they opposed it.

So, that bill was left in committee. However, it still remains a dangerous bill. It is possible to tack that on as an amendment to some 15 or 16 bills that are still before the committee. So far, we have won the first round on that bill. Just what the result will be later is still to be determined. We hope we will be successful.

Then, our friend the Governor had his bill. It was the identical bill he had in 1947, identical, as to period, semicolon, and whatnot.

After very much discussion around the halls and corridors of the Capitol about this bill, what it might mean, what it might not mean, we had our hearing. At that time we were beautifully assisted as we were in the hospital bill that I mentioned, by insurance, by agriculture, by business generally, the Chamber of Commerce, Los Angeles Chamber of Commerce, the hospitals of California, and by our doctors.

We had two doctors. I shall call them by name now. Dr. Clifford Loos of Los Angeles, because he represented a group of voluntary insurance on a private basis. He made a very fine showing before the committee.

And then, Dr. Alson Kilgore, who, as you all know, has helped us so ably in the past, put on the finishing touches. At the conclusion of Dr. Kilgore's statements, the chairman said, "I see there are two members of my committee who are not here. It will be necessary to take the bill under advisement," where it still remains. We have not heard further.

Then, our old perennial. We have developed in California various specialists and we have developed a specialist on naturopathy legislation in Dr. Homer Woolsey of Woodland. It has been Dr. Woolsey's assignment for the last 25 or 30 years or so to come over to Sacramento and oppose this bill, which he does very well.

At present it is in committee, and we may or may not hear more from it. But that requires lots of time and lots of effort, and lots of danger of trading and all that sort of thing that takes place when bills like that come up.

This is what they will say: "Now, Doctor, we are all overboard for you so far as compulsory health insurance is concerned. But, now, this little innocuous bill here can't possibly bother you, because you are a doctor. And you know, my friend sponsored this bill and I want to give him a vote on that because I want him to give me a vote on my fixing up orange crates, or something like that."

Now, that is what I mean by trading, and that is why these seemingly innocuous bills cause us considerable headache.

Now, the bill on osteopathy. Frank MacDonald of Sacramento has qualified himself as being a specialist on osteopathy legislation and will oppose that bill for us when it appears.

Now, if Dr. MacDonald calls on you to come to Sacramento on that day, I want you to bring your wife and children, grandchildren, and come up and fill that committee room so full there won't be any room for anybody else to get in. Now, don't forget that.

Senate Bill No. 11 was a bill giving optometrists rights to do things that we think they shouldn't.

That bill was opposed in committee, but it was lost. It was passed out of committee. This was a Senate bill and it passed the Senate. We will have to oppose it in the committee in the Assembly.

That bill has not been set for hearing in the Assembly as yet.

Then we have the physical therapy bills. The physical therapy bills are in two groups—the American Physical Therapists and the Physical Therapists of California. The American Physical Therapists are the ones we believe have the proper bill and we are having a little trouble getting these two together. We will have to do it. An amendment has been offered and we will have to consider that.

Then, we have the rebate bill. That is a thing that has been talked about in California as well as the rest of the United States. The rebate bill was introduced by the chairman of the Interim Committee in the Senate appointed to study this problem. He introduced the bill that would not only apply to the practice of medicine but to other professions and business as well.

I would just like to tell you a little bit about what happened at that time.

The Senate Interim Committee referred to previously introduced a bill to abolish rebating. There apparently was no objection to this bill, but when it was heard before the committee Mr. Bauer of the Los Angeles Better Business Bureau told the committee he felt the bill was too broad since it included commercial firms as well as physicians. It was his idea to hit directly at the physicians, leaving everybody else out. His remarks opened up the subject to the extent that committee members felt the bill was not broad enough and should cover all lines of commerce. As a result, the author of the bill was instructed to amend it to make it broader. In his speech before the committee Mr. Bauer made repeated reference to doctors, carrying his references to the extent that Senator Kraft of San Diego rebuked him for, as he put it, "continually harping upon the doctors."

Now, I just give you this so that particularly you people from Los Angeles may know what we have to endure up there sometimes.

Now, the nurses' bill. You heard about that problem. But the nursing bill was introduced. We have a bill of our own but we decided not to push our bill particularly. We thought it was possible that the nurses and the hospitals might get together. There seemed to be considerable confusion before the committee, so much so that the chairman of the committee appointed sub-committees to study the problem and hear amendments. When the sub-committees reported back, there were so many amendments suggested by the nurses and by the hospitals that the bill was in complete confusion.

I don't think anybody understands it, and I am sure the doctors present didn't understand it, and it is still in the state of confusion. It is resting before the committee. What will be done by the committee, we don't know.

Now, these are just some of the highlights that I have tried to give you. If there are any particular bills that any of you are interested in, I would be glad to discuss them with you at any time. Or, if there are any you wish to ask about now, I will be glad to answer your questions if I can.

The problem in Sacramento this session has been the worst that I have experienced. I have been there since 1940 and this has been the worst session because there have been more bills, more committee hearings, more amendments suggested to the bills which require more constant watching and more burning of the midnight oil than at any other time.

I want to leave you with this idea. First of all, I wish to say that doctors all over the state and various members of the California Medical Association, including our President, who came to Sacramento and had a rather tough time before the committee, also many other members of the California Medical Association, have helped us no end.

This one thing I think we should think of finally, and this may meet with the approval of some of you and not of others. That is—and I say this because I have talked it over with Dr. Halverson—the various appropriations that are asked by the Department of Public Health. It has been pointed out that the Department of Public Health is growing into the biggest bureau that we have. And it won't be so very long until we won't have to worry about compulsory health insurance. We will have it wrapped up pretty well in our Department of Public Health.

The various appropriations that are asked are a bit astounding, sometimes, when you see the figures. We are not saying that there isn't reason for some of this, but the question comes about how much money should be expended. For instance, $900,000 is asked for the rheumatic heart disease program for the rest of this year. The next five years the expenditure is supposed to approximate around $6,000,000 for rheumatic heart disease.

We all know we have rheumatic heart diseases in California. We all know many people suffering from rheumatic heart diseases that need to have personal care as well as hospitalization, and so on.

All right, then comes cerebral palsy: $4,000,000 was asked for the purpose of erecting a hospital, and then $2,000,000 for the maintenance of that hospital as well as appropriations for the care of the chronically ill.

Also, $25,000,000 to aid in hospital construction. And that is in addition to some $16,000,000 to $17,000,000. That is in the budget.

Now, I leave it to you gentlemen if you don't think those figures are astounding enough that they should require the attention of the profession.

Again, I wish to thank all of the members who have helped so well, and I assure you that you will probably be called upon again because the session is a long way from over. (Applause.)

SPEAKER ALESEN: That report will be referred to Committee No. 1.

Committee on Scientific Work, Dr. L. Henry Garland. Dr. Garland, have you any additions?

DR. GARLAND: No additions, Mr. Speaker.

SPEAKER ALESEN: Committee No. 1.

Cancer Commission, Dr. Lyell C. Kinney. Have you any additional report?

DR. KINNEY: No additional report.

SPEAKER ALESEN: Committee No. 1.

Editorial Board, Dr. Dwight L. Wilbur.

DR. WILBUR: No additional report.

SPECIAL COMMITTEES

SPEAKER ALESEN: Delegates to the American Medical Association, Dr. John W. Cline. Is Dr. Cline in the house?

DR. CLINE: No additional report.

SPEAKER ALESEN: Committee No. 1.

Physicians' Benevolence Committee, Dr. Axcel E. Anderson.

DR. ANDERSON: Nothing to add at present.

SPEAKER ALESEN: Committee No. 1.

Advisory Planning Committee, Mr. John Hunton.

MR. HUNTON: No additional report.

SPEAKER ALESEN: Committee No. 1.

Committee on Revision of Constitution and By-Laws, Dr. Sam J. McClendon of San Diego.

Dr. McClendon, do you have a word for us at this time?

DR. MCCLENDON: Mr. Speaker, and members of the House, I would like to defer our report until Tuesday night as our information and some of the detailed things are not yet in order.

SPEAKER ALESEN: I can tell the members of the House that this committee has been working hard and long at this job. So we have to accept their excuse.

Committee on Crippled Children's Act, Dr. Frederic Ewens. Dr. Ewens?

COMMITTEE ON CRIPPLED CHILDREN'S ACT

DR. EWENS: Mr. President, Mr. Speaker, and members of the House of Delegates: At the 1948 meeting of the House of Delegates of the C.M.A., a resolution was adopted calling for the study of "The Authority Underlying the Crippled Children's Act." The Council of the C.M.A. set up a committee for this study and it has been my privilege to act as chairman, aided by John C. Sharp of Salinas and Lloyd Hardgrave of San Francisco. The committee has functioned and submits the following report:

It is the desire and intention of the committee to improve standards and facilities for needy, handicapped or crippled children. However, it is our considered opinion that the Crippled Children's Act, as it now stands, needs amendment and revision to insure that such needy handicapped or crippled children will receive such care.

It is further our opinion that the Act, as it exists at present, is too loosely drawn, and in many aspects is subject to constructive criticism.

We feel that the State Department of Health and its present administrative officers, who are responsible for the execution of the Act, are doing an honest, conscientious and sincere job in cooperation with the California Medical Association, the doctors of the State of California, and the hospitals of California.

In suggesting revisions to the Act, there is no intent to hamper the care of needy handicapped or crippled children, but it is our considered opinion that definite clarification of some of the sections should be made.

There is a possibility that at some future time there might be officials responsible for the Act who might develop a considerable bureaucracy, which would lead not only to resentment on the part of physicians, but also perhaps poorer care for those in need, because of regimentation and even a form of socialized medicine.

The administration of the Act should be based on the language of the law and not on the changing administrative personnel.

In the hands of unreasonable or bureaucratic persons, the statute as it now stands, we feel, would compel the State of California to care for all children from the age of birth to 21 years of age.

In Article 2, Section 249, the words, "Developing and extending" as viewed by the committee are too hazardous, in that the official in charge can develop and extend without additional legislation into a bureaucratic dictatorship. The committee recommends elimination of these words.

We believe that the terminology, as presently used and interpreted, means to improve the care of needy crippled children and to bring into effect services for such needy children where they are not available. However, another connotation may be put on this, as stated previously.

Section 250 describes a handicapped child as a "physically defective or handicapped person under the age of 21, who is in need of services."

In Instructions, the Department of Health in interpreting the section has under Paragraph 5 given "ear conditions leading to loss of hearing, such as chronic otitis media and chonic blocking of the Eustachian tube."

Under Paragraph 6 of the instructions from the Department, rheumatic heart disease and congenital heart disease are classified as crippling deformities. We recognize that congenital heart disease is a crippling disease, and this might come under purview of the Crippled Children's Act, but if rheumatic fever or rheumatic heart disease is an infectious process, then any other form of infection is a crippling form of disability, and, if one organ can be crippled due to infection, then any other organ can be crippled due to infection and, therefore, any infectious process leaving any damage to any other organ of the body could be classified as a handicapping disability. And, hence, the individual could be called a crippled child.

We, therefore, question the wisdom of including rheumatic heart disease and other diseases as being conditions which have been commonly accepted as crippling.

Section 251, "Defining Services": Services listed in this article include any or all of the following:

(a) Expert diagnosis.
(b) Medical treatment.
(c) Surgical treatment.
(d) Hospital care.
(e) Physiotherapy.
(f) Occupational therapy.
(g) Special treatment.
(h) Materials.
(i) Appliances and their upkeep, maintenance, care and transportation.
(j) Maintenance, transportation, or care incidental to any other form of services.

Under item (a), "Expert diagnosis" should read, "Proper diagnosis and treatment." Item (g), "Special treatment," needs further definition and clarification. Item (j), "Maintenance, transportation, and so forth," should be eliminated entirely.

Section 253. The words, "Expert diagnosis," found in line 4 should be eliminated and the words, "Proper diagnosis and treatment," used in their place. The following should be added to the end of the paragraph: "Diagnostic clinics or conferences herein mentioned are to be set up only in locations where such facilities are not available at present." This would save the duplication and building of public clinics adjacent to clinics or facilities now established.

Section 255. The committee decided that this section as worded permits too great a latitude for social workers to offer services, and we suggest the following: "The agency or social worker, designated by the Superior Court, shall have the proper power and authority to make inquiry into the financial needs and resources of the parents of the child for whom medical care is being requested."

Sections 254 and 255. In the phrase, "either wholly or partly unable," the word "partly" be removed. In paragraph (b) the sentence reads, "that the child need services"; we would have in addition, "as determined by a licensed physician." This would eliminate the possibility of a clerk overriding the decision of the doctor in the case.

Section 256. "Upon receipt of the authorization of the Department, shall furnish such services for the child as in its judgment are necessary and proper."

It should not be the province of the Department to determine the necessity and proper care of the handicapped child, but it is the responsibility of the doctor in charge of the child. The recommendations of the doctor based on his experienced judgment should only be carried out by the Department.

Section 270. Under "Annual appropriations" it should not be mandatory to collect 1/10 mil. Funds should be raised by the county as a county tax measure commensurate with the powers for so doing as set forth in the various county government acts.

This committee has devoted much time to the thorough study of this Act. I have hurriedly enumerated several dangerous parts which you can readily recognize as socialized medicine written under the guise of assisting the handicapped and crippled child.

Although at present the situation appears healthy, you are confronted with the possibility in the future of being faced with the problem of the doctor taking orders from a political or bureaucratic group.

The committee feels that the handicapped child fares much better if the doctor with his experienced judgment could have the power to guide the child's treatment.

It is obvious that the State has no specific power to investigate the financial status of the responsible parties who request help under the provisions of this Act.

Because of the mandatory provisions you are compelled to pay 1/10 mil toward building a bureaucracy in place of the regular county methods of taxation.

We of the committee hope that the House of Delegates will recognize the need for changes in this Act, and we request the Council of the C.M.A. to instruct the Legal Department to undertake the work of correcting these ambitious and ambiguous sections and to present them in the proper manner so that the plight of the needy handicapped and crippled children will be improved without destroying the free institution of the practice of medicine. (Applause.)

SPEAKER ALESEN: Thank you, Doctor. The report will be submitted to the Reference Committee No. 1.

Now, the Committee on the Study of Alcoholism, Dr. Cullen W. Irish. Dr. Irish, have you any additional report?

(No response.)

I think the attention of the House ought to be called to the fact that when this committee's report was read before the Council, approbation was widespread.

Let's read the members of this committee: Cullen Ward Irish, chairman; J. Martin Askey, Hall G. Holder, George H. Houck, and Malcolm H. Merrill.

Now, the Blood Bank Commission, John Upton. Is there any additional report?

DR. UPTON: No additional report.

SPEAKER ALESEN: Committee No. 1.

Committee on Industrial Health, Christopher Leggo.

DR. LEGGO: No addition.

SPEAKER ALESEN: Committee No. 1.

Committee on Rural Medical Service, Carroll B. Andrews.

DR. ANDREWS: No additional report.

SPEAKER ALESEN: Committee No. 1.

Mr. Secretary, is there any old or unfinished business?

SECRETARY GARLAND: Mr. Speaker, no report.

SPEAKER ALESEN: Members of the House of Delegates, there is one beautiful little chore I have the opportunity to do right now, the opportunity to call your attention to the services of the delegates who have served this House for 25 years. Dr. John Hunt

Shephard of Santa Clara County, will you please stand up and take a bow? (Applause.)

Now, Dr. Robertson Ward is recognized by the Chair for a discussion of the World Medical Association. Dr. Ward.

DR. WARD: Thank you, Mr. Speaker. Dr. John Cline, who is chairman of the American Medical Association delegates, asked me if I would say a few words about the World Medical Association that has been recently formed and which you are urged as doctors of medicine to support and join, if you find it possible.

This organization, we feel, can do a great deal for medicine throughout the world in helping to spread medical knowledge, particularly in helping the doctors in the countries where the government has come to dominate the practice of medicine, to be cognizant of how free medicine is practiced.

It is for that reason I am addressing you now and urging your support of the World Medical Association. Thank you. (Applause.)

A MEMBER: Mr. Chairman, I think Dr. Cline asked that we be told where we could get that information.

SPEAKER ALESEN: Dr. Ward, would you answer the question? Where can the information be obtained?

DR. WARD: Here at this meeting at the registration desk. And when you get home if you want to write the California Medical Association, their office will be able to give you all the information.

SPEAKER ALESEN: The Speaker's attention is called to the fact he committed a serious error in overlooking another of our very fine senior citizens, Dr. Robert A. Peers from Colfax. Dr. Peers, will you stand, please? (Applause.)

Ladies and gentlemen, it is now 6:00 o'clock. It is the plan to recess this meeting until 7:15, at which time the place of the meeting has been changed to the Ballroom in order to accommodate the members of the Woman's Auxiliary.

The purpose of inviting the ladies to meet with us—of course we always look forward to having them with us—but on this particular occasion Whitaker and Baxter, our public relations counsel, will give a report of unusual interest to all of you.

Now, it has not been possible to get this information to the ladies, so will you please invite them, and please get back at 7:15 promptly so we can get started.

The meeting is recessed.

. . . The meeting of the House of Delegates recessed at 6:00 o'clock p.m. to reconvene at 7:15 o'clock p.m. the same evening. . . .

HOUSE OF DELEGATES
MAY 8, 1949

The first meeting of the House of Delegates of the California Medical Association reconvened in the Ballroom of the Biltmore Hotel, Los Angeles, California, Sunday, May 8, 1949. The Speaker, Dr. Lewis A. Alesen, of Los Angeles, California, called the meeting to order at 7:30 p.m., and presided.

SPEAKER ALESEN: We told you earlier in the day that we had something very good for you at this session this evening.

By way of introduction I should like to quote one verse from a Kipling poem.

"But the woman that God gave him,
Every fiber of her frame,
Proves her launched for one sole purpose,
Armed and engined for the same,
And to serve that single issue
Lest the generations fail,
The female of the species must be
Deadlier than the male."

(Applause.)

Ladies and gentlemen of the House of Delegates and members of the Woman's Auxiliary, it is a pleasure to introduce the lady that I am going to introduce. This lady is from the firm of Whitaker and Baxter.

They tell me she is the power behind the throne. Her husband tells me she has written and is writing much of the material that is about to be used in our campaign to frustrate the enemies of good sound medicine.

Miss Baxter is a modest, mild-mannered woman, but don't let that deceive you. She wields a powerful hand.

Without further ado I want to introduce our public relations counsel, Miss Baxter. (Standing applause.)

MISS LEONE BAXTER: This isn't a lady's brief notes for a talk. It's a much more significant item than that.

This is the keynote of the doctors' campaign against government-controlled medicine. It's a proof of a poster designed for display in the reception rooms of the doctors of this country.

And because this national campaign is more or less California's baby, or at least its brainchild, we thought our California friends would like this little preview and explanation of the keynote poster.

This is a beautifully done reproduction of the celebrated Sir Luke Fildes painting, "The Doctor," with which every doctor and every doctor's wife is very familiar.

It shows the doctor, sitting in deep and intent concern at the bedside of his patient, a small child. It shows the parents hovering in the background, the mother in tears.

It is a human, moving scene. And it's a scene duplicated in its essentials hundreds of times by doctors in this room tonight.

Actually, it epitomizes something which doctors themselves never discuss much, the human factor in medical care, a factor which politically-controlled medicine would destroy utterly.

I'd like to read to you the interpretive caption which we have made a part of the reproduction. We tried very hard to write something that would accomplish our purpose and not impair the intent

of the painting. I hope you'll agree that the result won't set the good Sir Luke spinning in his grave.

"Keep politics out of this picture.

"When the life, or health, of a loved one is at stake, hope lies in the devoted service of your doctor.

"Would you change this picture?

"Compulsory health insurance is political medicine.

"It would bring a third party, a politician, between you and your Doctor.

"It would bind up your family's health in red tape.

"Political medicine would result in heavy payroll taxes, and inferior medical care for you and your family.

"Don't let that happen here.

"You have a right to prepaid medical care, of your own choice.

"Ask your doctor, or your insurance man, about budget-basis health protection.

"Under voluntary health insurance, your health is your own business. Keep it that way."

When we left California to manage the national campaign against compulsory health insurance, Whitaker and Baxter had great misgivings as to whether the doctors of other states would be as alert as California doctors were to the danger confronting the American medical system.

Development of this poster, with this appeal as a symbol of the national campaign, was our way of finding out how 140,000 individual doctors feel about personal participation in the campaign.

Today, the orders for this poster, ladies and gentlemen, are pouring into the national headquarters at the rate of 6,000 a week, which, along with very active campaigns now generating in the states, provides us with the proof we needed, that doctors generally know the real gravity of the threat confronting them, and are ready for action to preserve their profession.

We've had lots of troubles and expect more.

But today, Whitaker and Baxter both have a feeling of exaltation about this campaign.

We feel that this crusade to keep American medicine free is the most vitally important peacetime happening we shall see in our lives.

We believe the outcome of this campaign will be a guidepost, pointing out a government trend, to the left or to the right.

We are convinced that on the determination of this issue will hang the future course of this nation.

Personally, Whitaker and Baxter feel that if, in directing this campaign for American medicine, we can play some small part in winning that broader battle, we shall have done something to compensate in some small way for the many good things the American system has done for us, and for other Americans like us.

I fervently hope that we can impart some of that crusading feeling to others, because I can think of no greater satisfaction that any of us might have than to know that for certain we have defended successfully our heritage of freedom.

Today, ladies and gentlemen, that freedom is threatened.

Without the slightest question, those who would quench that spark of freedom are moving politically toward responsible positions in our government.

When the spark of life flutters and threatens to go out, I know that doctors sometimes pray for miracles, and then help to perform them.

America, ladies and gentlemen, our whole country, needs a miracle today, if it's to survive as a free nation. And the first test is in the field of medicine.

American doctors never faced a greater crisis.

And never, ever, have they faced a greater challenge. (Applause.)

SPEAKER ALESEN: Thank you, Miss Baxter.

To introduce the next member of Whitaker and Baxter, we have asked our good friend Dr. Murray for an introduction. Dr. Murray.

DR. MURRAY: Mr. Speaker, Miss Baxter, Dr. Schriver, members of the Auxiliary and House of Delegates: I want to recount to you some of the things that happened in St. Louis that led to the appointment or the employment of the firm of Whitaker and Baxter. At the St. Louis meeting, which was soon after the November election, it was very evident that the American Medical Association was facing a very difficult problem, that of combatting compulsory health insurance on a national scale.

We were not in any way misled, nor were we in any way discouraged by the fact it was going to be a difficult job.

There was appointed by the Board of Trustees a committee consisting of four members of the Board of Trustees and three members of the House of Delegates of the American Medical Association, one of whom is Dr. John Cline, whom you all know, of course. Then having done that, what was the next step? It was all agreed that we would have to carry the message to the people, that this would be a grass roots problem of education. The battle would not be won in Washington only, nor by the influence that could be brought by people back home on the legislators in Washington.

The chairman of the Board of Trustees and the President of the American Medical Association called Dr. Cline and myself to consultation and he said, "Now, you fellows in California have been through a war, not once but twice. We realized that if you lost that war in California we would lose it nationally.

"Now, can you tell us who, in your opinion, can do this job for us on a national scale? Whom can we employ, and right away, to do this job for us?"

Without question we told him exactly what we knew had been accomplished in California by the firm of Whitaker and Baxter. And we recommended that they would do the things that would be best for American medicine, forgetting their own personal desires or ambitions and that they would do the job as best they possibly could, and that we felt that they would do just as good a job on a national scale as they had done locally.

This is exactly, ladies and gentlemen, the sequence of events and those who are delegates to the A.M.A. know that that is exactly what happened.

I want to tell you that that is why the firm of Whitaker and Baxter was employed by the American Medical Association, upon their record and experience in California. We felt that nationally it would not be any different except bigger, and we felt that the firm of Whitaker and Baxter was big enough to take on that assignment.

It is with pleasure that I present—not introduce, because you all know him very well—Clem Whitaker of the firm of Whitaker and Baxter, who is leading our educational fight in Chicago on a national basis. (Applause.)

[NOTE: Mr. Whitaker's address was published in the June issue of CALIFORNIA MEDICINE.]

SPEAKER ALESEN: Thank you, Whitaker and Baxter.

At this time the House of Delegates will recess to make way for the meeting of the administrative members of the California Physicians' Service. When that meeting is over, we shall reconvene to continue the remainder of this meeting.

. . . The meeting of the House of Delegates of the California Medical Association recessed at 8:15 o'clock p.m. to make way for the meeting of the administrative members of the California Physicians' Service. . . .

* * *

The meeting of the House of Delegates reconvened in the Ballroom of the Biltmore Hotel, Los Angeles, California, Sunday, May 8, 1949. The meeting was called to order at 10:20 p.m. by Vice-Speaker Charnock, who presided.

VICE-SPEAKER CHARNOCK: The last item of business this evening is new business, which includes the introduction of resolutions.

We will ask each member who introduces a resolution to come forward and give his name and county for the recorder, and to have the resolution in triplicate.

Are there any resolutions to present to the House of Delegates?

NEW RESOLUTIONS

No. 1. Regarding Reimbursement to Alternates to the A.M.A.

Introduced by T. J. LAUGHLIN, Los Angeles County

WHEREAS, It is of utmost importance that representatives of the various constituent state medical societies at the sessions of the House of Delegates of the American Medical Association be thoroughly conversant with the policies and functions of said House of Delegates, and

WHEREAS, Such knowledge can be obtained only through practical experience and personal contact by attendance at these sessions of the House of Delegates of the American Medical Association, and

WHEREAS, The office of Alternate to the House of Delegates of the American Medical Association is an honored and important office, placing a very real responsibility upon the one who holds it to be prepared to serve as a Delegate and to act in the best interests of Medicine, and

WHEREAS, It is not deemed just or equitable to expect an Alternate to be financially penalized by the expense of travel, etc., incurred in attending sessions of the House of Delegates of the American Medical Association, which sessions they should attend to meet the responsibility of their office; therefore be it

Resolved: By the House of Delegates of the California Medical Association, that Alternates from California to the House of Delegates of the American Medical Association shall be reimbursed by the California Medical Association for their expenses incurred in attendance at these meetings, beginning with June, 1949, meeting at Atlantic City, in the same manner as Delegates are reimbursed.

VICE-SPEAKER CHARNOCK: It will be referred to Reference Committee No. 3.

I see that Dr. Thienes has come in. He has asked permission to make an announcement. The Chair recognizes Dr. Clinton H. Thienes.

DR. THIENES: Mr. Speaker, ladies and gentlemen, I wish to announce that on Thursday night of this week at 7:00 o'clock there is to be a dinner, the annual dinner of the Medical Research Society of Southern California. I am speaking particularly, therefore, to physicians of this general community, but any of the members who happen to be remaining over Thursday are certainly invited, and urged to attend.

The Medical Research Society of Southern California was organized to assure the availability of animals for medical research. In other words, it is the organization for combatting the anti-vivisection movement. There is a national society and we have various regional societies. This is a very important movement.

You heard Dr. Murray this morning discuss the anti-vivisection bills and our own bill, which is the first step toward making the use of animals in laboratories a humane procedure.

We cannot expect to advance in medical research without the use of proper animals, and in California we have 16 per cent of the population of this part of the state who are opposed to the use of animals in medical research.

The poll for the country at large indicates about 5 per cent of the people are opposed to the use of animals in medical research. Here we have 16 per cent. I am confident that most of that 16 per cent could have their minds changed if there were a proper educational program, and some of the Medical Research Society of Southern California organized first by physicians, most of them just as I, working in laboratories—pharmacologists, bacteriologists, and so on.

We are now attempting to expand our membership and our activities. We have already included the dentists and the veterinarians. We have many

nurses in our organization. We wish to have the wives of physicians and the wives of dentists and the wives of veterinarians.

We wish to have laboratory technicians and we wish to have members of the community at large who have no connection with medicine except that they wish their families protected.

Now, we wish as large a number as possible of the officials of the California Medical Association to be present, especially those from this area, at this meeting Thursday night. The place is the Linda Gales Dining Room at La Cienega and Beverly Boulevard in the Rexall Building. It is going to be necessary, of course, for those who come to the dinner to have reservations, and you can call my office at the University of Southern California, Richmond 4111, Station 369. Will you put that down in your notebooks and call tomorrow? It is important. Thank you.

VICE-SPEAKER CHARNOCK: We will now resume the introduction of resolutions.

DR. BENJAMIN FREES (Los Angeles County):

No. 2. Regarding Schedules of Insurance Carriers

Introduced by BENJAMIN FREES, Los Angeles County

WHEREAS, A rapid increase in coverage by voluntary sickness insurance programs is considered by the American Medical Association as the best answer to the demand for compulsory health insurance, and

WHEREAS, Many recognized insurance carriers today are insuring, on an indemnification basis, employee groups against the costs of sickness and hospitalization, and are handicapped in their efforts to expand this coverage without further cooperation from Doctors of Medicine as relates to agreements concerning fee schedules, and

WHEREAS, The Executive Committee and the Council of the Los Angeles County Medical Association have met a number of times with representatives of insurance carriers and insured employee groups, and have seriously studied the problem of fee schedules in relation to salable insurance programs that would cover an adequate portion of employed persons, looking forward to the approval of schedules that would be acceptable as full payment of fees for service, and

WHEREAS, Following this preliminary study it is the belief of the Council of the Los Angeles County Medical Association that this important subject be dealt with on a state, rather than a county level; therefore be it

Resolved: That the Council of the Los Angeles County Medical Association memorialize the House of Delegates of the California Medical Association to request the Council of the California Medical Association to consider this program of prime importance in meeting with positive action the issue of compulsory health insurance, and institute studies that will result in action without delay.

VICE-SPEAKER CHARNOCK: It is referred to Reference Committee No. 3.

DR. SYDNEY F. THOMAS: Just a word of introduction first. This is merely a resolution concerning the procurement of military personnel and really an attempt to put on record what has already been started in a number of places, and which has been somewhat active in some of the counties.

No. 3. Regarding Doctors In Military Service

Introduced by SYDNEY F. THOMAS, Alternate from Santa Clara County

WHEREAS, Help has been sought by the Office of Defense in procurement of medical personnel, and

WHEREAS, If proper procurement is done no maldistribution of medical talents would result; now therefore be it

Resolved: That the State (and County) Medical Society take the initiative rather than wait for government dictation in the matter of provision of medical personnel. That the medical service counsel be instructed to work out in liaison with the military authorities a truly reasonable estimate of the number necessary and be subjected to careful civilian scrutiny. That when the required number of doctors has been determined a survey be made at county society level of the availability of potential military medical men. That a roster be drawn up by a properly appointed committee in each county society of all the doctors in the order of their availability for military service with consideration similar to those which guided the Procurement and Assignment Boards being operative in determining the priority on this roster. That consideration be given to a system of rotation between military service and civilian service in the case of war so that the burden would not fall too exclusively on one particular group. That additional study be made of the utilization of civilian physicians on a part-time basis for staffing military hospitals in times of peace and war; now therefore be it further

Resolved: That the Council be empowered to set up a commission or committee on procurement of military personnel with the instruction that this committee work out carefully and prepare a plan for execution by the state and county medical society councils, as outlined above.

VICE-SPEAKER CHARNOCK: Do we have any more resolutions?

DR. WILLIAM A. SUMNER (San Francisco County): This resolution is introduced at the request of the Section on Neuropsychiatry.

No. 4. Regarding By-Law Amendment to Change the Name of a Scientific Section

Introduced by WILLIAM A. SUMNER, San Francisco County

WHEREAS, At the business meeting of the Section on Neuropsychiatry on April 12, 1948, it was formally passed and ordered that the Association be requested to change the name of the Section to the Section on Psychiatry and Neurology; now therefore be it

Resolved: That Chapter IX, Section 1(a) of the By-Laws be changed as provided in Chapter IX,

Section 1(b) by substitution of the words "Section on Psychiatry and Neurology" for "Section on Neuropsychiatry."

VICE-SPEAKER CHARNOCK: This resolution is referred to Reference Committee No. 3.

Dr. Robertson Ward.

DR. ROBERTSON WARD (San Francisco County): This resolution was introduced at the request of the San Francisco County Medical Society delegates.

No. 5. Regarding Support of A.M.A. Program

Introduced by ROBERTSON WARD, San Francisco County

WHEREAS, There has been for several years a considerable growing threat to the voluntary method of rendering medical care to the people of the United States; and

WHEREAS, The people of the United States and the medical profession rightfully look to the American Medical Association for leadership in matters pertaining to medical care and the welfare of both the people and the profession; and

WHEREAS, The American Medical Association has, by action of its House of Delegates at the interim session, launched a campaign to educate the public concerning medical care; and

WHEREAS, The program involves the support of individual physicians both in spirit and financially, as to the assessment of $25.00 placed upon each member; now therefore be it

Resolved: That the House of Delegates of the California Medical Association heartily endorses the program of the American Medical Association and offers its support, both in spirit and in urging members to comply with the assessment; and be it further

Resolved: That a copy of this resolution be sent to the Board of Trustees of the American Medical Association, the Speaker of the House of Delegates and members of the House of Delegates of the American Medical Association, the chairman of its Coordinating Committee, and to all members of the United States Congress.

VICE-SPEAKER CHARNOCK: This resolution is referred to Reference Committee No. 3.

DR. JAMES RAPHAEL (Alameda County): This resolution is introduced at the request of the Alameda County delegates.

No. 6. Regarding Hospital Standardization

Introduced by JAMES RAPHAEL, Alameda County

WHEREAS, The 30-year trend in American medicine has seen the growth of numerous bodies without the framework of the American Medical Association, acting independently of the House of Delegates of the A.M.A., with the resulting division of its membership and the weakening of the policy-making power of the said House of Delegates; now therefore be it

Resolved: That the delegates from the California Medical Association to the American Medical Association be instructed to introduce a resolution to the effect that all extra-jurisdictional bodies now acting independently of the House of Delegates of the A.M.A. in matters of policy involving the membership as a whole be made responsible to the House of Delegates of the A.M.A., and be it further

Resolved: That the delegates from the California Medical Association to the A.M.A. be instructed to introduce a resolution to the effect that the House of Delegates of the A.M.A. appoint a committee made up of representatives of all minority and majority groups within its framework to study the problem of taking over the functions of hospital standardization and regulation now performed by extra-jurisdictional bodies; and be it further

Resolved: That the delegates from the California Medical Association to the A.M.A. be instructed to introduce a resolution to the effect that a plan of hospital standardization make provision for the local solution of local problems.

VICE-SPEAKER CHARNOCK: This resolution is referred to Reference Committee No. 3.

DR. WESLEY S. SMITH (San Diego County): I have several resolutions that our County Medical Society has asked to be introduced at this time.

No. 7. Regarding Public Relations

Introduced by WESLEY S. SMITH, San Diego County

WHEREAS, Each individual member of California Medical Association has paid the total sum of $310.00 into the treasury of said California Medical Association during the past four years as annual dues, to-wit: $100.00 in 1946, $100.00 in 1947, $60.00 in 1948, and $50.00 in 1949, and

WHEREAS, The individual members of said C.M.A. have been informed that a large percentage of said annual dues is used for "Public Relations" activities, and

WHEREAS, The members of C.M.A. residing south of the Tehachapi Mountains are of the opinion that little or no practical benefit has inured to organized medicine under the existing method of administering said Public Relations, and

WHEREAS, The members of C.M.A. residing south of the Tehachapi Mountains comprise more than 60 per cent of the entire membership of C.M.A., and the Southern Counties are now in dire need of a more coordinated and effective program of local Public Relations, and

WHEREAS, It has come to the attention of the members of C.M.A. residing south of the Tehachapi Mountains that various other professional groups (for example, Southern California State Dental Society), are beginning to organize and carry on more and more Public Relations activities on a "grass roots" or local level rather than on a state level, and

WHEREAS, The members of the C.M.A. residing south of the Tehachapi Mountains firmly believe that Public Relations activities carried on at a "grass roots" or local level would prove more effective and less expensive than those carried on at a state level; now therefore be it

Resolved: That the Public Relations Committee of C.M.A. be instructed to review carefully the exist-

ing method of administering the Public Relations activities of C.M.A., to investigate thoroughly the present expenditure of C.M.A. funds for Public Relations activities, and to determine the effectiveness of the present method of administering the Public Relations activities of C.M.A. in relation to its cost. Be it further

Resolved: That said Public Relations Committee of C.M.A. be instructed to investigate the possibility of allocating C.M.A. funds to component medical societies to be used for Public Relations activities on a "grass roots" or local level, with special emphasis being placed on the determination of whether Public Relations activities handled on a "grass roots" or local level would not prove more effective and less expensive than the existing method of administering the Public Relations activities of C.M.A. Be it further

Resolved: That said Public Relations Committee of C.M.A. be instructed to investigate the possibility of allocation of C.M.A. funds to employ a firm of Public Relations Counsellors in the southern part of California, in order to provide the Southern Counties with better Public Relations on a local level by Public Relations Counsellors who know the local problems facing the Southern Counties at this time. Be it further

Resolved: That the Public Relations Committee of C.M.A. be instructed to study the Public Relations programs of the various other professional groups, such as Southern California Dental Society, to determine the effectiveness of said programs and the possibility of adopting a similar program for C.M.A.

No. 8. Regarding Field Representative

Introduced by WESLEY S. SMITH, San Diego County

WHEREAS, At the 1948 session of the House of Delegates of California Medical Association, a resolution was adopted requesting C.M.A. to effect closer and more adequate contact between itself and the Southern Counties, and

WHEREAS, C.M.A. thereafter stationed a "field representative" in Los Angeles, and

WHEREAS, During the past year it has become increasingly apparent that the numerous duties of said "field representative," in Sacramento and elsewhere, make it impossible for one person to be available when necessary at this office in Los Angeles, and

WHEREAS, Although the members of C.M.A. living south of the Tehachapi Mountains comprise more than 60 per cent of the total membership of C.M.A., the Southern Counties are still without a C.M.A. representative most of the time; now therefore be it

Resolved: That the Council and officers of C.M.A. be instructed to carry out the resolution adopted at the 1948 session of the House of Delegates of C.M.A., and that the Council and officers of C.M.A. take all steps necessary to establish a more adequate branch office in the Southern Counties in which representatives of C.M.A. will at all times be available for consultation and assistance.

No. 9. Regarding California Caravan

Introduced by WESLEY S. SMITH, San Diego County

WHEREAS, The members of C.M.A. have been informed that a large amount of the funds of C.M.A. is being used to put on the radio program known as "California Caravan," and

WHEREAS, Said radio program is generally concerned with the publicity for California Physicians' Service, and

WHEREAS, California Physicians' Service is at present a solvent corporation and well able to take care of and pay for its own public relations activities; now therefore be it

Resolved: That the Public Relations Committee of C.M.A. be instructed to study carefully the phases of organized medicine publicized by the radio program "California Caravan," that said Public Relations Committee of C.M.A. be instructed to review the use of C.M.A. funds to publicize California Physicians' Service, and that California Physicians' Service be instructed to pay for its own public relations activities.

VICE-SPEAKER CHARNOCK: Those resolutions will be referred to Committee No. 3.

DR. WILLIAM C. BLACK (San Diego County):

No. 10. Regarding Social Security

Introduced by WILLIAM C. BLACK, San Diego County

WHEREAS, Extension of "Social Security" to the self-employed of the United States has been advocated and will probably be considered and acted upon by the 81st Congress, and

WHEREAS, Such extension would include physicians and surgeons, and

WHEREAS, Provision for the exigencies of old age is an individual matter which should be left to the decision of self-employed individuals on a strictly voluntary basis, and

WHEREAS, So-called "Social Security" is in effect a socialistic compulsory tax scheme which cannot and has not provided proper, satisfactory, or acceptable insurance protection in this country or in other countries, and

WHEREAS, "Society Security" is actually one of the numerous entering wedges for the development of the Welfare State aimed at the destruction of individual freedom, individual initiative and responsibility, and the voluntary society which is the primary reason for the ascendancy of the United States of America, and

WHEREAS, The private insurance companies of the nation offer a large variety of flexible insurance plans designed to meet the great variety of desires for insurance protection by the people of this country; now therefore be it

Resolved: That the House of Delegates and the Council of the California Medical Association unanimously disapprove of the extension of so-called "Social Security" to physicians and surgeons and

that the Secretary of the Association be instructed to send copies of this resolution to

1. Members of the appropriate Senate and House Committees, and
2. The Board of Trustees of the A.M.A.;

and be it further

Resolved: That the delegates to the A.M.A. be instructed to introduce a similar resolution at their next meeting.

VICE-SPEAKER CHARNOCK: Referred to Reference Committee No. 3.

The Chair recognizes Dr. Breitman next.

DR. H. B. BREITMAN (Los Angeles County): This was originally one resolution that was split in two, and was unanimously approved by the Council of the General Practice Section of Los Angeles County.

No. 11. Regarding General Practice Sections In Hospitals

Introduced by H. B. BREITMAN, Los Angeles County

WHEREAS, The rapid and constant increase of medical knowledge the past twenty years has necessarily resulted in greater specialization with its greater demand on hospital facilities, leaving very little room for the general practitioner, and

WHEREAS, This trend is destroying the effectiveness of the general practitioner in treating the public and is undermining the prestige he has always had, and

WHEREAS, The high cost of medical care is in a large part due to this inability of the general practitioner to hospitalize and treat his patient, still the major part of the public, and this contributes greatly to the demand for socialized medicine, and

WHEREAS, These inequities have received official recognition as evident by the resolution passed unanimously by the A.M.A. House of Delegates on December 10, 1946, and later by the C.M.A. in May, 1947, encouraging hospitals to set up general practitioner services, and

WHEREAS, This resolution has either been ignored or ineffectually carried out by many large hospitals throughout the country; now therefore be it

Resolved: That the delegates of the C.M.A. reaffirm its resolution urging all approved hospitals having specialized sections in their staff setup to have a general practice section having the same standing as other sections with the same powers and privileges.

No. 12. Regarding General Practice Section

Introduced by H. B. BREITMAN, Los Angeles County

WHEREAS, The rapid and constant increase of medical knowledge the past twenty years has necessarily resulted in greater specialization with its greater demand on hospital facilities, leaving very little room for the general practitioner, and

WHEREAS, This trend is destroying the effectiveness of the general practitioner in treating the public and is undermining the prestige he has always had, and

WHEREAS, The high cost of medical care is in a large part due to this inability of the general practitioner to hospitalize and treat his patient, still the major part of the public, and this contributes greatly to the demand for socialized medicine, and

WHEREAS, These inequities have received official recognition as evident by the resolution passed unanimously by the A.M.A. House of Delegates on December 10, 1946, and later by the C.M.A. in May, 1947, encouraging hospitals to set up general practitioner services, and

WHEREAS, This resolution has either been ignored or ineffectually carried out by many large hospitals throughout the country; therefore be it

Resolved: That the delegates of the C.M.A. instruct the delegates from California to the A.M.A. House of Delegates to introduce a similar resolution at their next meeting making it mandatory for such hospitals, with continued approval contingent on such action, and that a copy of this resolution be sent to the American College of Surgeons with the request that that body voice approval of this resolution in its manual of Hospital Regulations.

VICE-SPEAKER CHARNOCK: These resolutions are referred to Reference Committee No. 3.

Dr. MacDonald.

DR. FRANK A. MACDONALD (Sacramento County):

No. 13. Regarding Staff Memberships

Introduced by FRANK A. MACDONALD, Sacramento County

WHEREAS, Hospital Districts were legalized in 1946 by the State Legislature under the Health and Safety Code, and

WHEREAS, District Hospitals constructed under the terms of this act were placed under the control of a board of directors, chiefly laymen, elected by the voters of the district, and

WHEREAS, High professional standards must be maintained in these hospitals to protect the health of the community and promote the welfare of the public; now therefore be it

Resolved: That this House of Delegates goes on record as being unalterably opposed to the appointment of practitioners other than fully qualified Doctors of Medicine to the professional staffs of these hospitals; and be it further

Resolved: That the Council of the California Medical Association be directed to assist by every legal means in carrying out the above resolution.

VICE-SPEAKER CHARNOCK: This resolution is referred to Reference Committee No. 3.

Dr. Davis is next.

DR. BURT L. DAVIS (Santa Clara County): This resolution was endorsed by the Council of the Santa Clara County Medical Society, and by the membership as a whole.

No. 14. Regarding the Standards and Qualifications of Doctors

Introduced by BURT L. DAVIS, Santa Clara County

WHEREAS, The future of the private practice of medicine rests with the present generation of physicians, and

WHEREAS, The California Medical Association has steadfastly supported and advocated the personal type of practice as we now know it and as it may be altered by the extension of voluntary health insurance plans; and

WHEREAS, Forces have been, and are, at work both here and in other countries which disrupt the solidarity of the medical profession by emphasis upon the differences in the personal preferences of doctors as to the type of their individual practices; and

WHEREAS, We have seen in Great Britain an example of the way in which this technique has split the forces of organized medicine, so that the state was enabled ultimately to exploit all of the groups, whether specialist or general practitioner, and

WHEREAS, The tendency has arisen for governmental agencies, insurance companies, and other organizations dealing with matters pertaining to health and medicine to make distinctions not only between general practitioners and specialists but also between specialists qualified by long experience and specialists qualified by board membership, and in addition to make academic distinctions among the various specialties, upon the basis of groupings among medical men themselves, and

WHEREAS, All physicians and surgeons in California licensed by the Board of Medical Examiners hold equivalent licenses and are equally permitted to practice medicine and surgery, and

WHEREAS, There are already laws enacted and in force which have been so interpreted that the work authorized under these acts may be performed only by holders of certificates granted by Medical Specialty groups whose legal authority does not supersede that of the Board of Medical Examiners, and

WHEREAS, These certificates were originally intended only as bases for standards among the members of the profession and not for a legal classification of doctors, and

WHEREAS, The California Medical Association has endorsed, and continues to endorse, the granting of Specialist Certificates for the purpose for which they were intended, but not for legal differentiation between physicians, and

WHEREAS, The California Medical Association is an organization of physicians and surgeons holding equal licenses to practice granted by the State of California, and

WHEREAS, The California Medical Association represents its members equally regardless of training or type of practice; now therefore be it

Resolved: That this House of Delegates of the California Medical Association deplores this tendency to create fissures, widen gaps, and accentuate differences between groups of doctors; and be it further

Resolved: That this House of Delegates instructs the Committee of Public Policy and Legislation of the California Medical Association to use its good offices and those of the society as a whole to impress upon legislative bodies, public health officials, and administrators of these various laws and acts the urgent need for amendments to the existing laws in order to correct the inequities now present not only in these laws, but in their administration and in addition to guard against these evils in the future; and be it further

Resolved: That the California Medical Association shall bring these matters to the attention of each component county medical society in order that the administration of these laws may be closely scrutinized at the local level; and be it further

Resolved: That this House of Delegates instructs the officers and members of the California Medical Association to advocate equal treatment of physicians by insurance companies, governmental agencies and others so that duly licensed doctors of medicine are considered equally in the eyes of the law.

VICE-SPEAKER CHARNOCK: This resolution is referred to Reference Committee No. 3.

DR. WILBUR BAILEY (Los Angeles County): On Page 26 of the Annual is a report on the codification of medical ethics, of which I am chairman, and here are two short resolutions which have to do with that committee report.

No. 15. Regarding Fictitious Names

Introduced by WILBUR BAILEY, Los Angeles County

WHEREAS, The recent decision of the Attorney General of California reemphasizes the fact that it is illegal for corporations or fictitious institutions to engage in the practice of medicine in California, and

WHEREAS, We note increasing numbers of so-called "Foundations," "Institutes," "Diagnostic Associations," "Tumor Centers," etc., not a few of which are operated by laymen or persons with dubious qualifications; now therefore be it

Resolved: That for the information and protection of the public, members or groups of members of the California Medical Association shall whenever possible avoid practicing under fictitious names and shall attempt to use only their own name or names on office doors, letterheads and other places visible to the public. In the case of bona fide established medical groups with regional or geographical names, the names of the founding or senior medical member shall whenever possible appear in conjunction with the title of the group, and, of course, on letterheads, etc., the name or names of all medical associates. And be it further

Resolved: That this resolution shall be brought to the attention of all component county medical societies with the request that they give it due notice in their publications and announcements.

No. 16. Regarding Non-Resident Members of The American Medical Association

Introduced by WILBUR BAILEY, Los Angeles County

WHEREAS, The By-Laws of the American Medical Association at the present time permit a physician to maintain membership in one county medical as-

sociation and in the American Medical Association, although he may leave and practice in an entirely different section of the country, and

WHEREAS, A physician under such circumstances has no responsibility to the local county medical society, and in turn cannot be held responsible by that society for his actions; now therefore be it

Resolved: That our delegation to the American Medical Association be instructed to present a resolution and to secure appropriate By-Law changes so that a physician who has moved to a new community must affiliate with the county medical society in which he practices within eight months or lose his membership in the American Medical Association.

DR. BAILEY: So much for the Committee on Codification of Medical Ethics. This third one is an idea of my own which may net us good will from the public. We ask a good deal of them. Perhaps we can do something for them.

No. 17. Regarding Ambulances

Introduced by WILBUR BAILEY, Los Angeles County

WHEREAS, Recently a private ambulance transporting a chronic invalid relied upon its siren to gain the right of way through a red light and was crushed by a truck, thus killing its three occupants, and

WHEREAS, Most drivers will yield to vehicles equipped with red lights but in some cases because of cab noises or deaf drivers no amount of siren screech will gain the right of way, and

WHEREAS, there are practically no medical emergencies requiring great haste in private ambulance transportation, but on the contrary patients can be actually harmed by being jounced across town through a series of hairbreadth escapes, and

WHEREAS, recent newspaper comment has made it abundantly clear that the public bitterly resents having these vehicles race through the streets while the "peasants hop for cover," and

WHEREAS, Ambulance owners through their organization, the California Ambulance Association, have expressed the wish that ambulances equipped with red lights but not sirens because the sirens double the wear and tear on equipment as well as the cost of insurance. (For competitive reasons this organization wants such action to be statewide), and

WHEREAS, The desire to abolish these hideous noises is unanimous except for a handful of doctors with a flair for the dramatic and those ambulance drivers who seem to enjoy this modern counterpart of the old western custom of shooting up the town; now therefore be it

Resolved: That to save the lives of our patients and to protect the health of our citizenry, the California Medical Association goes on record as wishing to cooperate with the California Ambulance Association in its desire to remove ambulance sirens. And be it further

Resolved: That efforts be made to amend the State Vehicle Code so that the example of New York and other mature cities may be followed where low-voiced sirens on public emergency vehicles are sounded only at intersections and when necessary.

VICE-SPEAKER CHARNOCK: These will be referred to Reference Committee No. 3.

Are there any others?

R. J. LAFE LUDWIG (Los Angeles): This must sound like something of an anticlimax.

No. 18. Regarding Education or Indoctrination of Interns and Medical Students

Introduced by J. LAFE LUDWIG, Los Angeles County

WHEREAS, The present-day medical student, intern, and resident have in many instances received their premedical training in institutions where the subjects of economics, sociology, and political economy have been taught by teachers with a pronounced bias toward collectivism, and have been assailed from many quarters by all manner of propaganda favoring the welfare state, and

WHEREAS, There are at this time and have been for some time past organizations actively engaged in aggressive campaigns to misinform, mislead and confuse these medical students, interns, and residents, to the end that governmental control of our profession may ultimately emerge by default, and

WHEREAS, We in the medical profession have thus far taken no active steps to inform the coming generation of practitioners concerning the fundamentals of economics in general as they apply more specifically to the practice of the healing arts; now therefore be it

Resolved: That the President of the California Medical Association be instructed to appoint a special committee of five whose duty it shall be to cause to be prepared and to be circulated among all medical students, interns, and medical residents of the State of California as well as among all of the membership of the California Medical Association, at short intervals, an instructive and explanatory brochure discussing the fundamentals of economics as they apply to the practice of medicine. To this end, the committee is instructed to employ the services of a trained economist who firmly believes in the American system of private enterprise and is skilled in developing and presenting the thesis of economic freedom.

VICE-SPEAKER CHARNOCK: The resolution by J. Lafe Ludwig of Los Angeles County will be referred to Reference Committee No. 3.

Dr. Bender of San Francisco.

DR. WILLIAM L. BENDER (San Francisco County): I want to put the same resolution to the House of Delegates that I presented to the Administrative Members of C.P.S., relative to a coordinating committee to aid in the function of C.P.S.

I shall gladly forego re-reading it, if the chairman and the House of Delegates will agree.

VICE-SPEAKER CHARNOCK: We will agree that it can be handed in as you read it before the administrative body. Thank you, Dr. Bender.

No. 19. Regarding California Physicians' Service Coordinating Committee

Introduced by WILLIAM L. BENDER, San Francisco County

WHEREAS, California Physicians' Service has grown to size and scope of a multi-million dollar corporation, and

WHEREAS, The successful administration of such a corporation requires the maximum ability, time and effort that may be reasonably expected from the Board of Trustees of C.P.S., and

WHEREAS, The matters of policy, strategy and the correlation of C.P.S. activities to those of the medical profession as a whole have become an additional burden of great magnitude for the Board of Trustees, and

WHEREAS, The responsibility for conducting the actual business of C.P.S. and also for studying and deciding matters of policy and strategy are now an unjust imposition on the Board of Trustees of C.P.S.; now therefore be it

Resolved: That the Board of Trustees limit its activities exclusively to the efficient operation of the corporation, and be it further

Resolved: That all matters of policy, strategy and economic or political import which affect the operation of C.P.S., such as the number of beneficiary members acceptable, the income ceiling, the stability of the unit, etc., shall be studied by a Coordinating Committee to be created solely for this purpose, and be it further

Resolved: That the Coordinating Committee make recommendations on all such subjects to the Board of Trustees, who in fulfilling their obligation to the members of the C.M.A. should abide by them until disapproved by the Administrative Members, and be it further

Resolved: That the Coordinating Committee shall make such recommendations as promptly as practicable to the Administrative Members who shall retain the right of final approval or rejection, and be it further

Resolved: That the Coordinating Committee shall be composed of the President of the California Medical Association who shall act as chairman, chairman of the Council of C.M.A., President of the Board of Trustees of C.P.S., chairman of the C.M.A. Legislative Committee, and two members of the House of Delegates, who shall hold no other C.P.S. office, to be nominated from the floor of, and elected by the House of Delegates for a term of two years (excepting that one of the initial members shall be elected for a one year term), to serve no more than two consecutive terms, and be it further

Resolved: That the Coordinating Committee shall be expected to consult with official C.M.A. legal and public relations counsel on all problems confronting the committee, and shall be empowered to engage additional help in the field of statistics and economics as necessary, and be it further

Resolved: That on the adoption of this resolution by the House of Delegates, the Board of Trustees of C.P.S. shall be directed to refer to the Coordinating Committee all such matters of policy or strategy as defined herein.

VICE-SPEAKER CHARNOCK: This last resolution is referred to Reference Committee No. 3.

Is there any other new business? If there is no other new business, we will ask the chairmen of the Reference Committees to state the times and places their committees will meet.

(The committee chairmen gave the information.)

VICE-SPEAKER CHARNOCK: Is there any new business? If not, a motion to adjourn is in order.

. . . It was moved and seconded that the meeting be adjourned. The motion was put to a vote and was unanimously carried. . . .

. . . The first meeting of the House of Delegates adjourned at 11:00 o'clock p.m., to reconvene Tuesday, May 10, 1949, at 4:30 p.m. . . .

* * *

HOUSE OF DELEGATES
MAY 10, 1949

The second meeting of the House of Delegates of the California Medical Association convened in the Music Room of the Biltmore Hotel, Los Angeles, California, Tuesday, May 10, 1949. The Speaker, Dr. Lewis A. Alesen, of Los Angeles, California, called the meeting to order at 4:30 p.m., and presided.

SPEAKER ALESEN: Will the meeting please come to order.

The Chair recognizes Dr. Carl Hadley of San Bernardino, chairman of the Credentials Committee, for a report. Dr. Hadley.

DR. HADLEY: We have enough for a quorum, Mr. Speaker.

SPEAKER ALESEN: Mr. Secretary, shall we proceed with the roll call?

SECRETARY GARLAND: Yes, sir.

. . . . The roll was called by the Secretary, and a quorum was reported present and acting. . . .

SPEAKER ALESEN: The Secretary will make the announcement concerning the location of our Convention for 1950.

SECRETARY GARLAND: Mr. Speaker and members of the House: The Council has not chosen next year's meeting place yet. There will be an attempt to do so tomorrow morning at an early hour, and we will notify all of you as soon as possible.

SPEAKER ALESEN: Now, Mr. Hunton informs me that after the dinner recess we shall reconvene in the Ballroom. Of course, it is up to the House of Delegates to determine what time, but your speaker would most humbly urge that it would be as soon as possible. We have a lot of work to do tonight, so I suggest we recess at 6:00 o'clock and meet again at 7:15.

At this time the order of business is the election of officers.

ELECTION OF OFFICERS

The Chair will entertain a nomination for the office of President-Elect.

DR. J. NORMAN O'NEILL (Los Angeles): Mr. Chairman.

SPEAKER ALESEN: Dr. O'Neill.

DR. O'NEILL: Mr. Speaker, members of the House, I really don't know what to say. I feel like a member of the CIO nominating President Roosevelt. (Laughter.)

The candidate for President-Elect is a man whom I have known for a great many years. He is well-known to all of you. He has been a member of the Council of the Los Angeles County Medical Association for about ten years.

He was then elevated to the Council of the State Society. He has done some very excellent work as a delegate to the American Medical Association.

He has put in many trying and arduous hours as a trustee of the California Physicians' Service, and in that one department alone has rendered invaluable service in looking after you doctors in a great many ways of which you probably are not entirely cognizant or aware.

During the war he carried a great deal of responsibility, working in the disaster committee which was functioning throughout the various hospitals, and it took a great deal of time.

I have talked to people, members of the California Medical Association, all the way from San Francisco to San Diego. I have interviewed past-presidents of the California Medical Association. I have talked to potential candidates for that office, and I have talked to the doctors out in the neighborhoods and various communities, and I haven't heard one dissenting voice for the man that we are going to nominate.

He is not only a Native Son—that may please some of you, although he doesn't wear it on his sleeve, I am happy to say—he is a graduate of Stanford Medical School, and he knows the problems of the general practitioner.

He knows the problems of the industrial surgeon, for he has spent many years on the Industrial Complaint Committee, and he is largely responsible for what increases we have been able to obtain in our fee schedule for industrial work.

He has some very fine Turf Club patients. I have tried to get them away from him but I haven't been able to because they love him, and rightly so.

It gives me great pleasure to place in nomination the name of Dr. Donald Cass for President-Elect of the California Medical Association. (Applause.)

SPEAKER ALESEN: The name of Dr. Donald Cass has been placed in nomination for President-Elect. Are there further nominations?

DR. E. T. REMMEN: I move the nominations be closed and the Secretary be instructed to cast a unanimous ballot for Dr. Cass.

A MEMBER: I second that motion.

SPEAKER ALESEN: Is there any discussion?

All those in favor of the motion signify by saying "aye."

. . . The motion was put to a vote and was unanimously carried. . . .

SPEAKER ALESEN: The Chair notes the motion is unanimous. Dr. Donald Cass has been nominated as your President-Elect, and the Secretary will cast the ballot.

SECRETARY GARLAND: The ballot is cast. (Applause.)

VICE-SPEAKER CHARNOCK: The next order of business is the selection of a Speaker. Dr. Alesen, incumbent.

President Askey.

PRESIDENT ASKEY: Mr. Speaker, members of the House of Delegates: Since the institution of the office of the Speaker of the House of Delegates, there have been five members of your Association that have held that office. It was Dr. Edward Pallette first, Dr. Roblee, Dr. Lowell Goin, the man who is speaking, that you honored very highly, and the present Speaker of your House.

I think that because of the work which that office entails, it needs a man who has demonstrated his ability to give you the service that you deserve. You need a man who will spend the onerous time that is necessary in that office.

It needs a man who has demonstrated that he has those abilities.

Without making any further speech, I hereby place in nomination the name of Dr. Lewis Alesen for Speaker of this House of Delegates. (Applause.)

A MEMBER: Mr. Chairman, I would like to second that nomination and move that the nominations be closed and that the Secretary be asked to cast a unanimous ballot for Dr. Alesen.

VICE-SPEAKER CHARNOCK: Is there a second to that motion?

A MEMBER: I second it.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that the nominations be closed, and that the Secretary cast a unanimous ballot for Dr. Alesen. All those that are in favor will signify by saying "aye."

. . . The motion was put to a vote and was unanimously carried. . . .

VICE-SPEAKER CHARNOCK: I note, Mr. Secretary, that that is unanimous and the Secretary is instructed to cast a unanimous ballot.

SECRETARY GARLAND: The ballot is cast.

VICE-SPEAKER CHARNOCK: Dr. Alesen has been elected. (Applause.)

SPEAKER ALESEN: Thank you.

The next order of business is the selection of a Vice-Speaker. Nominations are in order.

DR. JOHN RUDDOCK: Mr. Speaker and members of the House of Delegates: I take great pleasure at this time in placing in nomination your present incumbent, Donald Charnock, and I will let his many years of service and his record speak for itself.

SPEAKER ALESEN: The name of Dr. Charnock has been placed in nomination.

Dr. J. Sampson of Santa Monica.

DR. SAMPSON: It is my pleasure to second the nomination of Donald Charnock as Vice-Speaker of the House of Delegates.

SPEAKER ALESEN: Dr. Clifford Loos.

DR. LOOS: Mr. Speaker, members of the House of Delegates: In placing in nomination the candidate I have in mind, I think it is only right that some of the delegates who are a little distant from Los Angeles should understand a situation that exists in this county of ours.

We have in Los Angeles a two-party system in the province of medicine and that runs along just as tranquilly and beautifully as a multiparty does in Venezuela and other places I could mention. (Laughter.)

It has been in the minds of some of us that a one-party system is the best system for a medical society. I am one of those naive people who engage in childish pursuits to have this happen. I haven't been too successful.

In order to bring about harmony in our midst—you have all heard of this—we have had many love feasts and they were delightful things to attend. But the resolutions we adopted at those love feasts didn't last long enough for the food in our stomachs to be digested.

Some of us tried the precarious feat of straddling the fence. Some of us have had to have quite a bit of perineal repair. (Laughter.)

We decided to try to do something about it this year. According to custom, a meeting was called, an organization meeting of the Los Angeles delegates, to organize, get a chairman and a steering committee. This meeting was well attended and the committee of nine for the steering committee was nominated, but there were three nominees too many, and it was decided upon motion by Dr. Remmen that the committee be extended to 12.

It was a fair committee. It met several times and it attempted to be as fair as it could be. I was there, and I know. I was a member of the committee. Among the various names that the committee presented as possible candidates for office of the C.M.A., some were unopposed. Your newly-elected President-Elect was unopposed. Your newly elected Speaker was unopposed.

Then came the position of Vice-Speaker. There were four names presented to the steering committee and we decided to be fair and not make the choice there by the 12 of us but to present the four names to the caucus that was to be called. The caucus was called. The four names were presented. One man withdrew. We balloted on the three remaining. Of the three remaining, one man received more votes than the other two.

Now, the sad part of all political campaigns is that whenever there is a contest by ballot, there has to be a human sacrifice. That I hate, but the gods must be appeased and that seems to be the rule of running for office; there is always a human sacrifice.

So, the man who was selected by this caucus was the man that I am privileged to introduced to you tonight.

This was, as I consider, a duty placed upon me, not one that I chose, and not one that indicates in any way how I might vote, because we all have our free vote. But I was instructed to report to you the results of that caucus of the Los Angeles delegates and alternates. There were 90 there, or a few under or over 90. Some of the alternates voted also. So, at this meeting it was decided to present the name of a man who was past-president of the Board of Medical Examiners, who has been for two years Secretary of the Los Angeles County Medical Association. He has fulfilled his duties well. He is well-liked, and I believe honestly if this man were to run for office on the county level, he would be unequalled. Two years ago I couldn't have said that. Two years ago I voted against him myself.

In these two years I think he has proven his ability. He has spent much time in the office as secretary. He is editor of our Bulletin, and he is a man that I believe is well-qualified for the position that he was named for.

But, before I reveal his name—you are all wondering what in the world this can be I imagine (laughter)—before I reveal this great secret I want to tell you this man I esteem as I esteem Don Charnock. Don Charnock is one of my best friends and has done a personal favor I will never forget.

Dick Bullis is the man I am going to name, and Dick Bullis is also a friend, and I esteem both of these men so highly I know that the one defeated will take defeat with a smile and will not make it a partisan matter and get his friends about him and start a revolution.

I know both of these men are not that kind and I know that if either one of these men is elected to office, you are not going to be disappointed.

The difficulty with our high offices is there are not enough of them for the good men we have to go around, and I think we ought to pass a resolution, or change the constitution so we have, say, 100 offices on the state level so we can give everybody a position, because there are so many worthy men.

But, ladies and gentlemen, it is my pleasure to present to you for your consideration for the office of Vice-Speaker of the House of Delegates of the C.M.A., Dr. Richard Bullis.

Dick, will you stand up so they can take a look at you? (Applause.)

SPEAKER ALESEN: Are there any further nominations?

DR. MAGOON (Santa Clara): Mr. Speaker, as you have heard, Dr. Bullis has filled many positions in the field of medicine, both within and without the C.M.A., capably and with distinction.

I am sure he will fill the office of Vice-Speaker in the same manner.

It is a privilege and a real pleasure to second the

nomination of Dr. Richard Bullis of Los Angeles. (Applause.)

SPEAKER ALESEN: Are there any further nominations? If not, the nominations are declared closed and we shall proceed with the ballot.

Will the tellers, T. E. Reynolds of Alameda, Carl L. Mulfinger of Los Angeles, Robert O. Pearman of San Luis Obispo, and R. J. Prentiss of San Diego, proceed to distribute the ballots on the office of Vice-Speaker. The candidates are Richard Bullis and Donald Charnock.

DISTRICT COUNCILORS

The next order of business is the election of District Councilors, three-year term. The Third District, Harry E. Henderson, Santa Barbara, term expiring.

Mr. Secretary, have you the nominees for this post from the Third District?

SECRETARY GARLAND: Mr. Speaker, the delegates from the Third District have nominated Dr. Harry E. Henderson to succeed himself.

SPEAKER ALESEN: Are there any further nominations for the post of Councilor for the Third District? If not, how will you proceed?

SEVERAL MEMBERS: Voice.

SPEAKER ALESEN: Those in favor of electing Dr. Harry E. Hendson of Santa Barbara to succeed himself as District Councilor, please signify by saying "aye."

. . . The motion was put to a vote and was unanimously carried. . . .

SPEAKER ALESEN: Mr. Secretary, please note and cast the ballot on it unanimously.

SECRETARY GARLAND: The ballot is cast.

SPEAKER ALESEN: Dr. Henderson is elected.

The Sixth District, Dr. Edwin L. Bruck of San Francisco, term expiring.

SECRETARY GARLAND: Mr. Speaker, members of the House, the Sixth District delegates nominate Dr. Laurence Montgomery to fill the vacancy left by Dr. Bruck.

SPEAKER ALESEN: Dr. M. Laurence Montgomery has been nominated by the delegates of the Sixth District. Are there any other nominations at this time? If not, how will you vote?

SEVERAL MEMBERS: By voice.

SPEAKER ALESEN: Those in favor of electing Dr. Montgomery as Councilor for the Sixth District, signify by saying "aye."

. . . The motion was put to a vote and was unanimously carried. . . .

SPEAKER ALESEN: So ordered. Mr. Secretary, will you cast a unanimous ballot.

SECRETARY GARLAND: The ballot is cast, Mr. Speaker.

SPEAKER ALESEN: Ninth District, John W. Green, Vallejo, term expiring.

SECRETARY GARLAND: Mr. Speaker, we have a unanimous nomination from the delegates of that district for the name of Dr. John W. Green of Vallejo to succeed himself.

SPEAKER ALESEN: Dr. John W. Green of Vallejo has been nominated to succeed himself as Councilor from the Ninth District.

Are there other nominations from the floor?

A MEMBER: Mr. Chairman, further nominations are not in order. The House has the privilege of accepting or rejecting the nomination of the District.

SPEAKER ALESEN: Your point is well taken. The Chair stands corrected.

All those in favor of electing Dr. John W. Green will signify by saying "aye."

. . . The motion was put to a vote and was unanimously carried. . . .

SPEAKER ALESEN: It is unanimous. Mr. Secretary, will you please cast the ballot.

SECRETARY GARLAND: The ballot is cast, Mr. Speaker.

SPEAKER ALESEN: The next order of business is the election of Councilors-at-Large, three year term.

COUNCILORS-AT-LARGE

SPEAKER ALESEN: Eugene F. Hoffman, Los Angeles, term expiring.

DR. RICHARD BULLIS: Mr. Chairman, members of the House of Delegates, it gives me pleasure to come forward to place in nomination the man who has been my boss in Los Angeles County since the last election.

I would like to say that you couldn't get a more competent, hard-working man for the position of Councilor-at-Large in this District to succeed Dr. Hoffman than Dr. Benjamin Frees. (Applause.)

SPEAKER ALESEN: The name of Dr. Benjamin Frees has been placed in nomination to succeed Dr. Eugene Hoffman. Are there other nominations?

DR. HOFFMAN: Mr. Speaker, I move the nominations be closed.

SPEAKER ALESEN: Are there other nominations? Is there a second to Dr. Hoffman's motion that the nominations be closed?

A MEMBER: I second the motion.

SPEAKER ALESEN: Those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, the vote is unanimous. Will you cast the ballot, please.

SECRETARY GARLAND: The ballot is cast, Mr. Speaker.

SPEAKER ALESEN: Now, nominations are in order for the term of Councilor-at-Large to fill the vacancy left by Dr. C. V. Thompson of Lodi, term expiring.

DR. HOMER WOOLSEY: Mr. Speaker, I take great pleasure in placing in nomination the name of Claude V. Thompson to succeed himself for this office of Councilor-at-Large.

SPEAKER ALESEN: The name of Dr. Thompson has been placed in nomination to succeed himself as Councilor-at-Large. Are there other nominations? If not, what is your action?

A MEMBER: Mr. Chairman, I move the nominations be closed and the Secretary be instructed to cast a unanimous ballot.

SPEAKER ALESEN: All those in favor signify by saying "aye."

. . . The motion was put to a vote and was unanimously carried. . . .

SPEAKER ALESEN: It is so ordered. It is unanimous. Mr. Secretary, will you please cast the ballot.

SECRETARY GARLAND: The ballot is cast.

SPEAKER ALESEN: Dr. Thompson has been elected to succeed himself.

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

SPEAKER ALESEN: The next order of business is Delegates to the American Medical Association for 1950 and 1951. The term will expire on December 31, 1951.

The term of Robertson Ward of San Francisco is expiring.

Dr. Kilgore.

DR. KILGORE: Mr. Speaker, I move the nomination of Dr. Ward to succeed himself.

SPEAKER ALESEN: Are there other nominations? The name of Dr. Ward has been placed in nomination to succeed himself. How will you act?

SEVERAL MEMBERS: Voice.

SPEAKER ALESEN: All those in favor please signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you cast the ballot.

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: The next office is that of Sam J. McClendon, term expiring.

DR. BALL (Santa Ana) : I place in nomination the name of Dr. Sam J. McClendon to succeed himself.

SPEAKER ALESEN: The name of Dr. Sam J. McClendon has been placed in nomination to succeed himself.

Are there other nominations? If not, how will you vote?

SEVERAL MEMBERS: Voice.

SPEAKER ALESEN: All those in favor of nominating Dr. Sam J. McClendon to succeed himself signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: There being no opposition, Mr. Secretary, will you cast a unanimous vote.

SECRETARY GARLAND: The ballot is cast, Mr. Speaker.

SPEAKER ALESEN: Dr. Sam J. McClendon has been elected.

Next is Dr. Lowell S. Goin, Los Angeles, term expiring.

Dr. J. Lafe Ludwig of Los Angeles is recognized by the Chair.

DR. LUDWIG: Mr. Speaker, members of the House of Delegates, I would like to place in nomination the name of a man who is now serving his second term in the Council of the Los Angeles County Medical Association, has served two terms on the Council of the California Medical Association, has acted as alternate to Dr. Goin for the past two years, has done an admirable job and one I am certain you could not improve on as Councilor to the American Medical Association.

It is my privilege and pleasure to nominate at this time Dr. Eugene Hoffman.

SPEAKER ALESEN: The name of Dr. Eugene Hoffman has been placed in nomination.

DR. BLACKMAN: I would like to second the name of Dr. Hoffman as delegate to the American Medical Association.

SPEAKER ALESEN: Are there further nominations? If not, all those in favor of the selection of Dr. Eugene Hoffman to succeed Dr. Lowell S. Goin please signify by saying "aye."

. . . The motion was put to a vote and was unanimously carried. . . .

SPEAKER ALESEN: It is unanimous. Will you cast the ballot, Mr. Secretary.

SECRETARY GARLAND: The ballot is cast.

SPEAKER ALESEN: Dr. Hoffman is elected.

The term of John W. Green is expiring. Nominations are in order.

A MEMBER: I would like to nominate Dr. Green to succeed himself as delegate to the A.M.A.

SPEAKER ALESEN: Dr. John W. Green has been nominated to succeed himself.

A MEMBER: Mr. Speaker, I should like to second that nomination.

SPEAKER ALESEN: Are there additional nominations?

A MEMBER: I move the nominations be closed and the Secretary be instructed to cast a unanimous ballot.

SPEAKER ALESEN: Is there a second?

A MEMBER: Second.

SPEAKER ALESEN: It has been moved and seconded that the nominations be closed and the Secretary be instructed to cast a unanimous ballot. All those in favor signify by saying "aye."

. . . The motion was put to a vote and was unanimously carried. . .

SPEAKER ALESEN: Dr. Green has been elected unanimously. Mr. Secretary, will you cast the ballot.

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Next is an additional delegate to A.M.A., no incumbent at this time.

Dr. Donald Cass of Los Angeles.

DR. CASS: I would like to nominate Lewis Alesen for the additional delegate.

VICE-SPEAKER CHARNOCK: The name of Dr. Lewis Alesen has been placed in nomination as delegate to the A.M.A.

A MEMBER: I would like to second that nomination with gusto. (Applause.)

VICE-SPEAKER CHARNOCK: Are there any other nominations for this position?

A MEMBER: I move the nominations be closed and the Secretary be instructed to cast a unanimous ballot for Dr. Alesen.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that the nominations be closed and the Secretary cast a unanimous ballot for Dr. Lewis Alesen. All those in favor signify by saying "aye."

. . . The motion was put to a vote and was unanimously carried. . . .

VICE-SPEAKER CHARNOCK: Mr. Secretary, it is unanimous, and will you cast the ballot.

SECRETARY GARLAND: Mr. Vice-Speaker, the ballot is cast with gusto. (Laughter.) (Applause.)

SPEAKER ALESEN: Thank you.

ALTERNATES TO AMERICAN MEDICAL ASSOCIATION

SPEAKER ALESEN: The next business for your attention is that of the selection of alternates to the A.M.A. First is the term of Dr. Anthony B. Diepenbrock of San Francisco, alternate to Dr. Robertson Ward. Nominations, please.

DR. H. BRODIE STEPHENS: I should like to nominate Dr. Anthony B. Diepenbrock to succeed himself as alternate to Dr. Robertson Ward as delegate to the American Medical Association.

SPEAKER ALESEN: The name of Dr. Diepenbrock has been placed in nomination to succeed himself.

A MEMBER: I move the nominations be closed.

SPEAKER ALESEN: Is there a second?

SEVERAL MEMBERS: Second.

SPEAKER ALESEN: It has been moved and seconded that the nominations be closed. Mr. Secretary, will you cast the ballot for Dr. Diepenbrock?

SECRETARY GARLAND: The ballot is cast.

SPEAKER ALESEN: Dr. Diepenbrock is elected.

Next is the term of Dr. Bon O. Adams of Riverside, alternate to Sam J. McClendon.

DR. A. E. MOORE (San Diego): I would like to place in nomination the name of Walter S. Cherry as alternate.

SPEAKER ALESEN: The name of Dr. Walter Cherry has been placed in nomination to succeed Dr. Bon O. Adams. Are there any other nominations?

A MEMBER: Mr. Speaker, I move the nominations be closed and the Secretary be instructed to cast a unanimous ballot.

SPEAKER ALESEN: Is there a second?

SEVERAL MEMBERS: Second.

SPEAKER ALESEN: It has been moved and seconded the nominations be closed and the Secretary be instructed to cast the ballot. All those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: Hearing no dissenting voices, Mr. Secretary, will you cast the ballot.

SECRETARY GARLAND: The ballot is cast, Mr. Speaker.

SPEAKER ALESEN: Next is the alternate to Dr. Eugene F. Hoffman.

Dr. Duke Mahannah, Los Angeles County.

DR. DUKE MAHANNAH: Mr. Speaker, members of the House of Delegates, it is my pleasure to nominate a general practitioner who I think would make a good representative to the American Medical Association. This man has many qualifications which we reviewed in the caucus of our delegation.

Without reviewing those qualifications, I wish to announce that he was the choice of our delegation and I place in nomination the name of Dr. Elmer J. Ball. (Applause.)

SPEAKER ALESEN: Dr. Ball has been nominated.

The Chair recognizes Dr. Frank Crandall of Los Angeles.

DR. CRANDALL: I would like to second the nomination and also move nominations be closed.

SPEAKER ALESEN: Just a minute, Doctor. Let's give them a chance.

DR. JOHN MARTIN (San Diego County): I would like to place the name of Frederic S. Ewens as alternate for this position.

SPEAKER ALESEN: The name of Dr. Frederic Ewens has been placed in nomination for the position of alternate to Dr. Hoffman. Are there other nominations for this position?

A MEMBER: I move the nominations be closed.

A MEMBER: I second the motion.

SPEAKER ALESEN: It has been moved and seconded the nominations be closed. All those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: Are the tellers finished with their job yet, or shall we appoint new ones?

I will appoint Dr. Carl Benninghoven of San Mateo County, Dr. Samuel Randall of Santa Cruz, Dr. Hollis Carey of Butte-Glenn County, and Dr. Alfred B. Wilcox of Santa Barbara County.

You are voting on the position of alternate to the American Medical Association. Elmer J. Ball and Frederic Ewens are the nominees.

DR. WARD: Could I ask the privilege of having the two candidates stand so we can have a look at them?

SPEAKER ALESEN: Yes.

Dr. Ball, will you please stand? (Applause.)

Dr. Ewens, will you please stand? (Applause.)

Thank you.

Next is Dr. Frank A. MacDonald of Sacramento, alternate to John W. Green. Nominations are in order for the position.

A MEMBER: I would like to place in nomination the name of Frank MacDonald.

SPEAKER ALESEN: The name of Dr. Frank MacDonald has been placed in nomination.

DR. WOOLSEY: I second that and move the nominations be closed, and the Secretary cast the ballot on it.

SPEAKER ALESEN: Dr. Woolsey, may we wait just one second to see if there be any other nominations.

If not, the motion has been made that the nominations be closed and the Secretary be instructed to cast the ballot. Are you ready for the question?

SEVERAL MEMBERS: Question.

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: Mr. Secretary, it is unanimous. Will you cast the ballot.

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: He has been elected to succeed himself.

Now, the post of alternate to additional delegate to A.M.A. Dr. Nippert of Los Angeles.

DR. EDWARD NIPPERT: Mr. Speaker, members of the House of Delegates, I wish I had the eloquence of one of the previous speakers and the silver-tongued oratory of my predecessor there, Dr. Loos, which I do not have; but I have the same determination and the privilege of presenting to you a name well known to you all; a man who is the founder of, I think, one of the greatest organization adjuncts of the State Society, which is the Public Health League; a man who has been battling for years for your profession and your pocketbooks and has succeeded up to now, and we hope will succeed in years to come.

For 15 years he was on the Legislative Committee of the C.M.A. He was president and secretary of the Los Angeles County Society, and he made a valuable reputation for himself. He is a conscientious worker and a man who produced results. He is also a trustee to Los Angeles County Medical Association, a member of the Physicians' Aid, and, most of all, and better yet, he is editor of the Annals of Western Medicine and Surgery.

So, with all these qualifications, gentlemen, you can't help but believe, as I do, that this man is qualified as an additional alternate to the American Medical Association, and I give you the name of Dr. Edmund T. Remmen. (Applause.)

SPEAKER ALESEN: The name of Dr. Edmund T. Remmen of Los Angeles has been placed in nomination for the additional delegate to the American Medical Association.

A MEMBER: Mr. Speaker, it gives me pleasure to second the nomination.

DR. WESLEY SMITH (San Diego): Mr. Speaker, inasmuch as this is a new position going to Southern California, we feel it entirely in order that District 1, composed of San Diego, Imperial, San Bernardino, Riverside and Orange counties be given an opportunity to place in nomination the name of an also very highly respected man.

This is a position which has never been filled. Los Angeles has already elected the delegate to the American Medical Association. The alternate's position, we feel, should properly go to one of the outlying districts.

The man we have selected to be the alternate for this new position is a man most of you know; a man who also has done outstanding things for medicine.

First of all, I might go back and tell you he—someone mentioned one of their candidates graduated from Stanford—this man graduated from the University of California in 1922. He settled in one of the beautiful districts of Southern California where he grows oranges and has since remained there serving in many, many responsible positions. Among them, of course, have been some terms on the Council of the Orange County Medical Association. Later he was its president.

He has served as a delegate to this House of Delegates for years and more recently and at present is a Councilor of our California Medical Association.

In addition to these qualifications he has an excellent background. He is the former chairman of the Industrial Section of the California Medical Association. He is the president of the Western Association of Physicians and Surgeons. It gives me a great deal of pleasure to put in nomination the name of John Ball, present Councilor, District No. 1. (Applause.)

SPEAKER ALESEN: The name of Dr. John Ball has been placed in nomination for this position.

Dr. Remmen.

DR. REMMEN: Mr. Chairman, members of the House, I allowed my name to be placed in nomination for the position of alternate delegate as a part of the harmony move. It is not an office which I seek. In fact, I don't seek any office at all. If I can carry a little water and do some work, I am most happy to do that.

I certainly do not wish to do anything which might create disharmony by depriving one of our smaller counties of what it considers proper representation on our delegation to the American Medical Association.

For that reason, Mr. Speaker, I beg to withdraw my name and to ask that the election of Dr. John Ball be made unanimous. (Applause.)

SPEAKER ALESEN: Dr. Remmen has withdrawn his name from nomination.

Are there other nominations?

If not, how will you act?

SEVERAL MEMBERS: Voice.

SPEAKER ALESEN: All those in favor of Dr. John

Ball as an additional delegate to the American Medical Association, signify by saying "aye."

. . . The motion was put to a vote and was unanimously carried. . . .

SPEAKER ALESEN: Please note, Mr. Secretary, the vote is unanimous. Will you cast the ballot.

SECRETARY GARLAND: The ballot is cast.

SPEAKER ALESEN: Mr. Secretary, do you have announcements to make on the election?

SECRETARY GARLAND: Mr. Speaker and members, in the ballot for position of Vice-Speaker, there was a vote of 220—Charnock 124, Bullis 96. Dr. Charnock is elected, Mr. Speaker. (Applause.)

SPEAKER ALESEN: Are there any additional announcements, Mr. Secretary?

SECRETARY GARLAND: No additional announcements, Mr. Speaker.

SPEAKER ALESEN: How about members of the Standing Committees?

SECRETARY GARLAND: That will be at a later time.

SPEAKER ALESEN: There are a number of items we would like to get off before the evening recess.

Dr. Justin J. Stein, president of the Veterans' Association of Los Angeles County, desires to introduce a resolution at this time out of order. The reason is that this is a non-controversial matter. This resolution covers something Dr. Stein believes is of great importance to the House of Delegates.

Will you permit Dr. Stein to be heard?

If there are no objections, the Chair moves he be heard. Dr. Stein.

DR. STEIN: Mr. Speaker and members of the House of Delegates: As Dr. Alesen has said, this is not a controversial issue. It has been passed on by the Steering Committee of the Los Angeles delegation and I believe it is an extremely important resolution. The resolution is as follows:

Resolution

WHEREAS, The procurement and assignment of physicians is one of the most important tasks with which the California Medical Association is confronted at the present time, and

WHEREAS, It has been estimated by the Armed Forces that there will be a shortage of 1,600 physicians by the end of July 1949, and that by the end of 1949 there will be a shortage of approximately 2,200 physicians, and

WHEREAS, The voluntary response by physicians educated at government expense or deferred from the draft in order to complete their education has been very poor, and

WHEREAS, Legislation of a discriminatory nature against physicians has been recommended by many lay individuals and organizations, and

WHEREAS, Medical matters of a military nature will become increasingly more numerous in the future; now therefore be it

Resolved: That the President of the California Medical Association be instructed at this session to appoint a permanent Committee on Military Affairs, whose duties shall be to:

1. Establish liaison between the Medical Advisory Committee to the Secretary of Defense and the American Medical Association on all matters pertaining to the procurement and assignment of physicians.

2. Assist in the formulation of any legislation, if it should be required, to obtain physicians for the Armed Forces during peace time.

3. Help establish proper quota of physicians for the Armed Forces during both peace and war time in the State of California.

4. Establish liaison between the various County Medical Societies of the state and keep them informed on all problems pertaining to the procurement and assignment of physicians.

5. To work with the Disaster Control Committee regarding the coordination of civilian disaster plans with those of the military during major disasters, such as fire, earthquake, atomic warfare, etc.

SPEAKER ALESEN: This resolution will be taken by the Secretary and presented to you after the report of the Resolutions Committee No. 3 at the evening session.

Mr. Secretary, have you a report on the election of office for alternate delegate to the American Medical Association?

SECRETARY GARLAND: Mr. Speaker, the poll is Ewens 112, Ball 103. Dr. Ewens is elected as alternate. (Applause.)

SPEAKER ALESEN: At this time the Chair will recognize Dr. Sam J. McClendon of San Diego, chairman of the Committee on the Constitution and By-Laws.

Dr. McClendon.

DR. MCCLENDON: Mr. Speaker, and members of the House: I am a great believer in the dictum of Henry Ward Beecher who said, "No souls were ever saved after the first 20 minutes."

I am not going to read this document at this time, but I would like to point out that originally 16 members of the California Medical Association were appointed as a committee to revise the Constitution and By-Laws.

In 1948, at your last session of the House, that particular document was referred to a committee of five. We have spent many hours and several days' total time in going over the Constitution and By-Laws for the purpose of revision. I will state that we have now completed our work of many arduous hours and are going to present for action for next year a complete revision of the Constitution and By-Laws. We hope this will be the only one necessary for the next ten to twenty years.

The major changes we have initiated have resulted from the change in the type of association that we have had.

The scope and magnitude of business affairs of this organization has grown tremendously during the past ten years and we feel more time should be given, particularly to business administration and

resolutions, and that type of thing. So, the new Constitution will provide for two meetings of the House of Delegates, a regional meeting and an interim meeting, and also provide for certain type of work and resolutions which can be introduced at one session and acted upon at the other.

Also, the committee felt the financial affairs of the Association require a more business-like handling. Therefore, the new Constitution will propose a more complete budgeting system and provide that expenditures beyond the budgets shall require a three-fourths vote of the Council.

The committee feels that the dual system of District Councilors and Councilors-at-Large is no longer in the best interests of the Association and is recommending that the state be redivided into 12 Councilor Districts with one Councilor from each, and with four officials given full Council membership.

Many additional modifications of the existing Constitution and By-Laws are proposed, including reorganization and strengthening of Standing Committees, clarification of membership qualifications and classifications, strengthening the procedure for referendum votes and other similar matters.

Also, I might state in this connection that we have in the New Constitution and By-Laws provided for a realignment of delegates to this House. Instead of having one delegate for each 50 members, under the proposed Constitution we would have one for each 100 members or fraction thereof.

In other words, your committee has felt the House was becoming too large and unwieldy for prompt and efficient action.

We have provided for a more democratic procedure in the election of delegates and have protected the right of each Councilor District to select its own Councilors.

I will not go into further detail at this time concerning the Constitution and By-Laws from the standpoint of details, because you will have this published at least twice in CALIFORNIA MEDICINE. You will have an ample opportunity to either oppose or approve what we have done.

I would like, however, at this time, to pay particular commendation to my committee. They have done an arduous job, a very thankless and onerous job. Dr. Richard O. Bullis, Dr. Leslie Magoon, Dr. Carl Mulfinger, and Dr. Robertson Ward have worked many hours on this.

I would like to give particular credit to our Executive Secretary, Mr. Hunton, who sat with us in every meeting and who has had voluminous work; and also Mr. Hassard, who has gone over this sentence by sentence to make sure there was no legal complication.

Mr. Speaker, I present the revision of the Constitution and By-Laws, which will lie on the table for one year.

SPEAKER ALESEN: Is this in the final form in which your committee wishes to present it?

DR. MCCLENDON: It is.

SPEAKER ALESEN: The Chair accepts this and it will lie on the table for one year.

At this time I suggest we have a recess. Please try to be back by 7:30. We will reconvene in the Ballroom at 7:30.

Ladies and gentlemen, this meeting is recessed.

. . . The meeting of the House of Delegates recessed at 6:15 p.m. to reconvene at 7:30 o'clock p.m. in the Ballroom. . . .

* * *

RECONVENTION OF HOUSE OF DELEGATES

The meeting of the House of Delegates reconvened in the Ballroom of the Biltmore Hotel, Los Angeles, California, Tuesday, May 10, 1949. The meeting was called to order at 7:30 p.m. by Speaker Lewis A. Alesen, who presided.

SPEAKER ALESEN: Will the House please come to order. We have a particularly important duty for the President to perform. Will he please approach now.

Mr. Secretary, will you make some announcements, please?

SECRETARY GARLAND: Mr. Speaker and members of the House, these are the nominations for the Standing Committees made by the Council, and subject to your ratification now:

Committee on Associated Societies and Technical Groups, J. Norman O'Neill, Los Angeles; Committee on Health and Public Instructions, George M. Uhl, Los Angeles; Committee on History and Obituaries, E. T. Remmen, Los Angeles; Committee on Hospitals, Dispensaries and Clinics, John C. Sharp, Monterey; Committee on Industrial Practice, Jerome W. Shilling, Los Angeles; Committee on Medical Defense, H. Clifford Loos, Los Angeles; Committee on Medical Economics, Arthur A. Kirchner, Los Angeles; Committee on Medical Education and Medical Institutions, Francis Scott Smyth of San Francisco; Committee on Membership and Organization, Verne G. Ghormley, Fresno; Committee on Postgraduate Activities, Charles A. Broaddus, San Joaquin; Committee on Publications, Keene O. Haldeman, San Francisco; Committee on Public Policy and Legislation, Peter Blong, Los Angeles; Advisory Committee, J. Lafe Ludwig, Los Angeles, to replace Peter Blong; Committee on Scientific Work, Clayton Mote; Physicians' Benevolence Committee, Axcel E. Anderson, Fresno, chairman.

SPEAKER ALESEN: What are your wishes for these committee appointments?

A MEMBER: I move they be accepted.

ANOTHER MEMBER: Second.

SPEAKER ALESEN: It has been moved and seconded that they be accepted. Is there any discussion?

All those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: So ordered.

At this time the Chair recognizes Dr. Askey, who

has an important duty to perform for the California Medical Association. Dr. Askey.

DR. ASKEY: Mr. Speaker, ladies and gentlemen of the House: In medicine there are a great many of our members who through the years have brought honor to our profession. And over the United States in the last few years it has been the custom to give to those people who have practiced for 50 years some little token of our appreciation of their success and the honor they have brought to their profession.

California Medical Association has a number of members who have practiced and been members of this Association for 50 years. We wish at this time to present to those members the pins and buttons which are emblematic of our esteem for our fellow practitioners of medicine.

From Alameda County we have the following Doctors of Medicine: C. M. Holmes Brazelton, Clark J. Burnham, Sr., E. Spence DePuy, Manuel M. Enos, Edward N. Ewer, A. Marion Field, Eve L. Harris, Murrey L. Johnson, Henry J. Kohlmoos, T. C. McCleave, Sr., Louise Oldenbourg, Kirby B. Smith, W. Barclay Stephens, Frank D. Walsh.

Dr. Enos, I guess you are the only one from Alameda County. Will you wait right here, please.

Los Angeles County: Lula Talbott Ellis, William Humes Roberts.

Sacramento County: George W. Dufficy.

San Francisco County: Herbert C. Moffitt, Wallace I. Terry.

San Mateo County: George W. Sevenman.

Dr. Enos, you alone are here to receive in person the award which we have for you in behalf of your 50 years of service as a member of our profession.

It is our honor to present you this emblem of this space of time you have honored our profession. I hereby grant this in the name of the California Medical Association, Dr. Enos. (Standing applause.)

DR. ENOS: Thank you very much.

PRESIDENT ASKEY: Thank you, Dr. Enos.

The other pins and buttons for persons whose names that I have read will be granted and given.

Now, there is one more honor which I, as your President, have, and it is a double honor because I was instructed by the Council of your Medical Association to present this to a member of your House.

There is a gentleman who is almost a has-been. Within a few hours he will be a has-been. I refer to the present chairman of the Council of the California Medical Association. This man, it has been my privilege to watch for several years of arduous work.

He has been a slave driver. He has been one who would not allow things to go by the board.

Your work had to be done and he saw that you did it. However, he is a slave driver that we all love. He is a man that we wish to honor tonight.

In behalf of the Council of the California Medical Association, I am asked to present to its outgoing chairman, Dr. Edwin Bruck, a token of the esteem in which we hold the man who has been chairman of our Council in the last few years.

I will ask Dr. Bruck to come here and accept this and to show you what we have given. Dr. Bruck. (Standing applause.)

DR. BRUCK: This is the miniature. This was a gavel when I became chairman of the Council and it has worn down to this size. (Laughter.)

Thank you, Dr. Askey and members of the Council.

The fact is that I have come to the time when I think I have done all the good I can do, and probably have stayed too long, and I feel that I should move out and make space for younger, quicker, faster, and better men; and that is the reason I have refused to go on. Everything I have done in the past has been something for the good of the California Medical Association as I saw it. I thank you. (Applause.)

SPEAKER ALESEN: We have five minutes now before the California Physicians' Service takes over. Can Committee No. 1 get any part of its report in, Dr. Royston?

REPORT OF REFERENCE COMMITTEE No. 1

DR. ERIC A. ROYSTON, Chairman: Mr. Speaker, members of the House. Before presenting this report, I wish to acknowledge the valuable help rendered this committee by the other members of the committee, Dr. Ivan C. Heron of San Francisco and Dr. Burt Davis of Palo Alto.

Altogether too frequently members of the committee will excuse themselves and leave the work to somebody else, but these men took hold right from the beginning and stayed with it until it was through.

Your committee has reviewed the reports of the General Officers, the Councilors, the President of the Trustees of the C.M.A., the Legal Department, and of the Editor of CALIFORNIA MEDICINE. We were very much impressed with the integrity and the earnestness with which the various officers of the California Medical Association have conducted their work during the past year. When medicine in general is so much under fire today from our Federal and State governments, it is most encouraging to be so definitely assured that the leaders of American Medicine are not going to depart from their Hippocratic oath.

These reports have been printed in the Pre-Convention Bulletin, copies of which have been distributed to all members of the House.

Your committee recommends the approval of these reports. Mr. Speaker, I move the adoption of this section of the report.

SPEAKER ALESEN: Is there a second to this?

A MEMBER: I second it.

SPEAKER ALESEN: All those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: So ordered.

DR. ROYSTON: Section 2: The report of the Council as presented in the Pre-Convention Bulletin has been carefully reviewed by your committee, together with the supplementary report on the Proposed Program of the California Medical Association for the Improvement of Medical Care. Your committee recommends the adoption of this report with its supplement. Mr. Speaker, I move the adoption of this section of the report.

SPEAKER ALESEN: Is there a second?

A MEMBER: Second.

SPEAKER ALESEN: All those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. ROYSTON: Section 3: Your committee has carefully reviewed the reports of the following committees: Executive Committee, Committee on Associated Societies and Technical Groups, Auditing Committee, Committee on Health and Public Instruction, Committee on History and Obituaries, Committee on Hospitals, Dispensaries, and Clinics, Committee on Medical Economics, Committee on Medical Education and Medical Institutions, Committee on Organization and Membership, Committee on Publications, Committee on Scientific Work, Cancer Commission, Advisory Planning Committee, C.M.A. Blood Bank Commission, Committee on Public Relations, Committee on Industrial Health, Committee on Rural Medical Service, Committee on Codification of Medical Ethics, and the Physicians' Benevolence Committee. Your committee recommends the approval of these reports. Mr. Speaker, I move the adoption of this section of the report.

SPEAKER ALESEN: Is there a second?

A MEMBER: Second.

SPEAKER ALESEN: Those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. ROYSTON: Section 4: Your committee has reviewed the report of the Editorial Board and highly commends Dr. Dwight Wilbur for the excellent work which he has done as chairman of this Board. Your committee recommends the adoption of this report but submits the following suggestion: That the members of the Editorial Board be supplemented by representation from the section on General Practice. Your committee recommends the approval of this section of its report.

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER ALESEN: Dr. Royston, this is merely a recommendation, is it not? It does not provide for a specific appointment at this time?

DR. ROYSTON: No.

SPEAKER ALESEN: Is there a second?

A MEMBER: Second.

SPEAKER ALESEN: All those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

DR. ROYSTON: Section 5: Your committee has reviewed the report of the Committee on Industrial Practice as published in the Pre-Convention Bulletin and recommends its adoption. Your committee feels, however, that a supplementary report on the progress of negotiations regarding the fee schedule would be welcomed by the membership of the California Medical Association. Mr. Speaker, I move the adoption of this section of the report.

SPEAKER ALESEN: Is there a second?

A MEMBER: Second.

SPEAKER ALESEN: All those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. ROYSTON: Section 6: It appears to your committee that Dr. Cullen Ward Irish and his committee for Study of Problems of Alcoholism in making their exhaustive study of this subject have contributed not only to the activities of the California Medical Association but have added a noble monograph to adorn the shelves of our medical and public libraries.

In addition to the seven recommendations which were submitted in printed form in the Pre-Convention Bulletin, the committee has also submitted 67 masterfully written pages on the subject of alcoholism which will probably become a standard reference for the future generations on this ancient and most important subject. We presume that this report will be printed in full in CALIFORNIA MEDICINE. We suggest that this report be made available to county medical and public libraries.

Your committee heartily recommends the adoption of this section of the report. Mr. Speaker, I move the adoption of this section of the report.

A MEMBER: I second the motion.

SPEAKER ALESEN: All those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. ROYSTON: Section 7: Your committee has reviewed the report of the Committee on Crippled Children's Act as submitted by Dr. Frederic Ewens and wishes to commend it on the breadth and scope of its exploration of this very important subject.

Your committee recommends approval of this report in principle and suggests that the following changes be inserted in the paragraph referring to Section 253 of the Crippled Children's Act so that the words, "expert diagnosis" found in line four will be eliminated and the words "proper diagnosis and treatment" be used in their place.

In the paragraph referring to Section 254 and 255 of the Act, your committee suggests that the

phrase, "either wholly or partly unable," be changed to read, "the test for eligibility for benefits should be based on a realistic appraisal of the child's need as determined by his physician or a medical advisory committee."

Your committee feels that time is of the essence in pursuing these recommendations and is aware that the State Act is dependent on the Federal Act in order to obtain federal tax moneys. Therefore, your committee suggests that the Council institute immediate steps to carry into effect these changes as far as possible in the present Legislature and also instruct the delegates to the American Medical Association to implement a national program to change the Federal Act in conformance with the principles in the report of this committee.

Your committee recommends the approval of this section of its report. Mr. Speaker, I move the adoption of this section of the report.

A MEMBER: I second it.

SPEAKER ALESEN: Is there any discussion? If not, all those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. ROYSTON: Section 8: Your committee feels that Dr. John Ruddock and his committee have done an excellent job in preparing their report on the committee on Postgraduate Activities. They have undoubtedly given many hours of study and thought to this most important subject. In addition to their printed report which appeared in the Pre-Convention Bulletin, they presented a supplementary report in two parts. The first part consisted of a report on the policies adopted by the Committee on Postgraduate Activities. The second consisted of a report of proposals for the future work of the committee.

Your committee recommends the adoption of this most excellent report and supplement with the following suggestions:

Part 1, paragraph 3 of the supplementary report be changed to read as follows: "The Committee on Postgraduate Activities will arrange postgraduate seminars at selected centers within the state which are easily accessible to most of the 4,000 non-metropolitan members. These seminars will consist of didactic lectures and/or clinical demonstrations in conjunction with the local county medical societies. Necessary expenses of the speakers or instructors and other miscellaneous costs will be absorbed by the Association."

In part 2, paragraph 2 of the supplement, it be changed to read as follows: "So that the director might be free for the field, as soon as practicable. the possibilities should be explored of employing an office assistant to the Director of Postgraduate Activities on a full time basis, and that adequate office space be made available immediately adjacent to the California Medical Association offices in San Francisco or in Los Angeles if circumstances warrant."

Paragraph 3 be changed to read: "That an Advisory Committee be appointed to meet with the Standing Committee at least once yearly," etc.

Paragraph 3 (c) be changed to read: "A surgeon, an internist, a pediatrician, an obstetrician, a general practitioner, and such other representatives as may be deemed advisable, to be selected at large."

Paragraph 4 to be deleted.

Paragraph 5 be changed to read: "That the California Medical Association continue its membership in the National Postgraduate organization of the A.M.A., and that a representative of the Postgraduate Activities Committee, preferably the Director, be selected to attend their yearly meeting, and such other meetings as are considered necessary and advisable by the committee."

Paragraph 6 be changed to read: "Insofar as deemed advisable the Postgraduate Committee cause to be published in CALIFORNIA MEDICINE, all postgraduate programs and opportunities fostered by the universities and other organizations available within the state."

Your committee recommends the approval of this section of its report. Mr. Speaker, I move the adoption of this section of the report.

SPEAKER ALESEN: Is there a second?

A MEMBER: Second.

SPEAKER ALESEN: Is there a discussion?

DR. ROBERTSON WARD: So far, has the chairman of the Postgraduate Committee approved the changes made in this program?

SPEAKER ALESEN: Dr. Ruddock, do you wish to answer that question?

DR. RUDDOCK: I have.

SPEAKER ALESEN: Is the answer satisfactory, Dr. Ward?

DR. WARD: Yes.

SPEAKER ALESEN: Is there any further discussion? If not, all those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. ROYSTON: Mr. Speaker, I move the adoption of the Report of Reference Committee No. 1 as a whole.

SPEAKER ALESEN: It has been moved and seconded that the Report of Reference Committee No. 1 as a whole be adopted. Is there any discussion? If not, all those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: It is so ordered

Thank you, Dr. Royston, and your committee for an excellent job well done. (Applause.)

The Chair now recognizes President Askey and recommends that he continue the job he almost finished before.

PRESIDENT ASKEY: It has been brought to my attention that one of our 50-year men just entered the room. We would like to honor him with a presentation of his 50-year badge. Actually it is 54 years.

This is Dr. Andrew Henderson of Sacramento County. (Standing applause.)

Dr. Henderson, it is with honor that I present you this pin.

DR. HENDERSON: Thank you. I wish to thank you for this recognition of long membership in this Association.

I rather feel that this body now has a fight on its hands quite as important as anything that has been done in the medical fraternity since the time 54 or 55 years ago when I joined the Association. That, of course, is the fight against socialized medicine.

About two weeks ago there appeared in Sacramento a gentleman who is a more than able graduate of the University of California, and his remarks were to the effect that 88 per cent of the people of the United States would be benefited by compulsory insurance. How he got that 88 per cent I can't even tell. So I would like to have some of the University of California men tell us where they got that 88 per cent. (Laughter.)

He said the United States was the only major country in the world that did not have socialized medicine, and I have no doubt he thought that he might have added that the rest of the countries had gone to the bow-wows and we might just as well go with them. (Laughter.)

Two or three weeks ago an article for socialistic medicine referred to a gentleman who had just been presented, as we were tonight, with a 50-year recognition of membership as a physician and surgeon of New York City. This gentleman in his remarks made the comment that in the next 50 years people would devote attention to preventive medicine as opposed to the cure of the failure of medicine. Now that is very nice, but I think I heard that same remark made some 50 years ago in Sacramento. I heard it in New York, I heard it in London, Paris, Berlin, and Vienna. It is true that preventive medicine was taken up at that time and the work done has resulted in the virtual elimination or great reduction of bubonic plague, typhoid fever, malaria, diphtheria—all those diseases, some of them which caused the death of millions of people.

There is no question but that our fight now, or your fight now, is the prevention of a socialistic type of medicine. (Standing applause.)

SPEAKER ALESEN: At this time the California Medical Association House of Delegates recesses and the California Physicians' Service meeting is turned over to Dr. Lowell Goin.

. . . The meeting of the House of Delegates recessed at 8:15 p.m. to reconvene after the meeting of the California Physicians' Service. . . .

* * *

RECONVENTION

The meeting of the House of Delegates reconvened in the Ballroom of the Biltmore Hotel, Los Angeles, California, Tuesday, May 10, 1949. The meeting was called to order at 10:10 p.m. by Vice-Speaker Charnock, who presided.

VICE-SPEAKER CHARNOCK: The next order of business is the Report of the Reference Committee No. 3, Dr. Jacobs, chairman.

REPORT OF REFERENCE COMMITTEE No. 3

DR. FRANCIS E. JACOBS, Chairman: Your Reference Committee No. 3, Dr. H. Clifford Loos, Dr. M. Laurence Montgomery and I, have met and considered all testimony presented regarding the By-Law amendment and the 18 other resolutions that were presented to the House of Delegates. There were no constitutional amendments submitted or held over from last year.

We have consulted with your President, Dr. Vincent Askey; with President-Elect Dr. Stanley Kneeshaw; with officers of the C.M.A.; with Council members of C.M.A.; with members of the Board of Trustees of C.P.S.; with representatives of various C.M.A. committees; with legal counsel; and with our Executive Secretary, Mr. John Hunton.

We have used the best witnesses available in considering the various resolutions. Your committee has used its best judgment in giving proper consideration not only to the county societies and individuals who proposed the resolutions but also the actual substance of the resolutions themselves. No audible voice was left unheard.

The problems which we have considered cover parts of the entire field of social, economic and administrative medicine. The field is broad and it is possible that we may have erred in judgment in the consideration of certain aspects of the resolutions. We have done the best job we could for you.

Reference Committee No. 3 respectfully submits the following report:

Resolution No. 1: This is a resolution embodying the thesis that alternates be allowed the same expenses for attendance at sessions at House of Delegates of the A.M.A. as the delegates. The committee and a majority of the witnesses felt that this is a progressive move which will be of great value to C.M.A. for years to come.

The committee recommends the adoption of this resolution.

VICE-SPEAKER CHARNOCK: Do I hear a second to the motion?

The question is on the adoption of this section of the report.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: All those in favor will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: This section is adopted.

DR. JACOBS: Resolution No. 2: A resolution embodying the thesis that C.M.A. on the state level can best negotiate with insurance companies regarding fee schedules for medical services.

The committee recommends adoption of this resolution.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that this resolution be adopted. The question is on the adoption of this resolution.

Those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

DR. JACOBS: Resolution No. 3: The intent of this resolution calls for a screening of all physician personnel for military service. The executive committee of C.M.A. already has met with representatives of the Army and Navy and is working along the lines suggested in the resolution. The Council of the A.M.A., through one of its committees, also is working on this thesis with the Surgeon General of the Army and Navy. The intent of the resolution is already being accomplished. The committee feels therefore that this resolution is unnecessary.

The committee recommends the rejection of this resolution.

VICE-SPEAKER CHARNOCK: Do I hear a second to that?

A MEMBER: Second.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report which will reject the resolution. Those that are in favor will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

DR. JACOBS: Resolution No. 4: This resolution embodies an amendment to the By-Laws by bringing up to date certain nomenclature in the By-Laws of the Constitution of the C.M.A. The intent is to change the words from "Neuropsychiatry" to "Section on Psychiatry and Neurology."

The committee recommends the adoption of this resolution.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded we adopt this section of the report.

All those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No. 5: The intent of this resolution is an affirmation by the C.M.A. of the new vigorous policy of the A.M.A. in combatting compulsion.

The committee recommends the adoption of this resolution.

VICE-SPEAKER CHARNOCK: Do I hear a second?

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded to adopt this section of the report. All those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No. 6: The committee has spent a great deal of time and study with witnesses and legal counsel concerning this particular resolution. Under ordinary circumstances it would favorably report the resolution to the House but it believes that because of the uncertainty of conditions, the timing is inappropriate.

The committee recommends the rejection of this resolution.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the committee's report, as to Resolution No. 6 regarding hospital standardization. It was introduced by James Raphael of Alameda County. Do you want me to read it?

SEVERAL MEMBERS: No.

A MEMBER: Mr. Speaker, I understand that the introducer of this resolution agrees with the recommendation of the committee. Is that correct?

DR. RAPHAEL: On advice of Mr. Hassard, I do agree with the recommendation of the committee.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report, No. 6, which would have the effect of rejecting the resolution. Is there any more discussion on it?

DR. BELT (Los Angeles County): It seems to me that this resolution merely seeks to give effect to the resolution already passed by the House of Delegates to the American Medical Association in 1948, in which the House of Delegates of the American Medical Association recommended to the hospitals a plan of hospital standardization. This is just to spur them along to do that. It is well-known how hospital standardization originated and how it was operated to the detriment of the great sections of the profession. It is also believed by all of us that it is time the American Medical Association agrees on the situation and sets up its own standardization for hospitals, in the interest of the whole profession, and not that section of it. That section has set up standards for its own purpose, and is using it for its own business.

I don't see why this is an inopportune time to ask the American Medical Association to put its own resolution into effect. I would like to have that explained.

VICE-SPEAKER CHARNOCK: Mr. Hassard, will you come forward to explain that part of it?

MR. HASSARD: Mr. Speaker, and members of the House of Delegates, the matter was discussed rather fully before the Reference Committee. You heard the author of the resolution state he is in agreement with the Reference Committee, and I would prefer not to discuss it further at this time, if I might have that privilege.

VICE-SPEAKER CHARNOCK: Is there any more discussion on this Resolution No. 6? The question is on the adoption of the committee's report, which in effect will reject this resolution.

Those that are in favor will signify by saying "aye."

. . . The motion was put to a vote. . . .

VICE-SPEAKER CHARNOCK: The Chair is in doubt. We will have a rising vote.

. . . A rising vote was taken on the motion. . . .

VICE-SPEAKER CHARNOCK: The resolution is rejected.

DR. JACOBS: Resolution No. 7: The purpose of this resolution is to decentralize the Public Relations efforts of C.M.A. and to point up the need for same.

The committee investigated this subject thoroughly and believes, in view of the facts that the Southern California office of the C.M.A. has been in existence for less than a year and that continued improvements are contemplated as the need arises, that this resolution appears to be premature.

The committee recommends rejection of this resolution.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report. Is there any discussion?

If, not, those in favor will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No. 8: The intent of this resolution is a complaint of the service rendered in San Diego through the Southern California office of the C.M.A. This is an honest and sincere complaint.

The committee rejects this resolution on the grounds that it feels some of the factors of the resolution have already been satisfied and there is evident assurance that there is already movement on foot to undertake the other measures referred to.

Your committee moves that this resolution be rejected.

VICE-SPEAKER CHARNOCK: Do I hear a second?

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report. Is there any discussion?

If not, those in favor will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No. 9: The intent of this resolution is to study the use of C.M.A. funds expended in advertising by radio through "California Caravan," particularly C.P.S. and other phases of organized medicine. The committee sees no harm in reviewing an expenditure.

The committee believes, however, that "California Caravan" along with C.P.S. is one of our better weapons of good Public Relations. The committee wishes to congratulate the Council of the C.M.A. and the Committee on Public Relations on doing a job well, for giving the physicians of California a winning team. The committee has changed the last paragraph of this resolution to read:

Resolved: That the Public Relations Committee of C.M.A. be requested to study carefully the phases of organized medicine publicized by the radio program, "California Caravan," that said Public Relations Committee of the C.M.A. be requested to review the use of C.M.A. funds to publicize California Physicians' Service.

The committee recommends the adoption of this resolution as amended.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report. Is there a second?

SEVERAL MEMBERS: Second.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Is there any discussion?

Those in favor of adopting this section of the report will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No. 10: The intent of this resolution is to keep the doctors out of the social security system and away from the collective state and on the road of good American free enterprise. The resolution was amended by changing the word "instructed" in the last paragraph to the word "requested."

The committee recommends the adoption of this resolution as amended.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report. Is there any discussion?

Those who are in favor of the adoption of this will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No. 11: This resolution reaffirms the recommendation of the C.M.A. and A.M.A. to foster the establishment of a General Practice Section in approved hospitals. The committee also feels that the General Practice Sections themselves should work harder on this problem and take the initiative in improving this condition.

The committee recommends the adoption of this resolution.

A MEMBER: Second.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report. Is there any discussion?

Those who are in favor of the adoption of this section of the report will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

DR. JACOBS: Resolution No. 12: The intent of this resolution is to have the A.M.A. include the setting up of General Practice Sections as one of the requirements in hospitals approved for teaching. This resolution was amended by changing the last paragraph so that it now reads:

Resolved: That the delegates of the C.M.A. request the delegates from California to the next A.M.A. House of Delegates meeting to introduce a similar resolution at their next meeting to recommend to the Committee on Hospitals of the A.M.A. to include in their requirements for approval of hospitals the establishment of a section on general practice with status similar to that of other departments wherever this is practicable.

The committee recommends approval of this resolution as amended.

VICE-SPEAKER CHARNOCK: Do I hear a second?

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report. Is there any discussion?

Those that are in favor of the adoption of this section will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: Is there a second?

DR. JACOBS: Resolution No. 13: The committee recommends rejection of this resolution and presents the following substitute resolution:

WHEREAS, Local hospital districts were authorized in 1946 by the State Legislature by adding a new chapter to the Health and Safety Code, and

WHEREAS, High professional standards must be maintained in hospitals built under the local hospital district law in order to protect the health of the community and promote the general welfare; now therefore be it

Resolved: That the C.M.A. firmly believes and represents that the public interest requires that the minimum standards for practice in district hospitals must be not less than the standards for practice that have been developed and established for private hospitals in this state that are approved for nurse or intern training.

The committee recommends that the substitute resolution be adopted.

VICE-SPEAKER CHARNOCK: Is there a second?

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: The question is on the adoption of the substitute resolution. Is there any discussion?

Those that are in favor of the adoption of this substitute resolution will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No. 14: The intent of this resolution is a complaint against the physician caste system in government, legal and insurance medicine. In the C.M.A. all are equal and there is no caste system.

The committee recommends the rejection of this resolution and submits this substitute resolution:

WHEREAS, The California Medical Association has endorsed, and continued to endorse, the granting of Specialist Certificates for the purpose for which they were intended, but not for legal differentiation between physicians, and

WHEREAS, The California Medical Association is an organization of physicians and surgeons holding equal licenses to practice granted by the State of California; now therefore be it

Resolved: That this House of Delegates requests the officers and members of the California Medical Association to advocate equal treatment of physicians by insurance companies, governmental agencies and others interested so that duly licensed doctors of medicine are considered equally in the eyes of the law.

The committee recommends adoption of the substitute resolution.

VICE-SPEAKER CHARNOCK: Is there a second?

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this substitute resolution. Is there any discussion?

Those that are in favor of the adoption of this substitute resolution will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No 15: The intent of this resolution is to discourage the use of fictitious names in the practice of medicine in California.

The committee recommends the adoption of this resolution.

VICE-SPEAKER CHARNOCK: Is there a second?

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report. Is there any discussion?

Those that are in favor of the adoption of this section of the report signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No. 16: The intent of this resolution is to require local county association membership, regardless of geographical migration of the physician, through A.M.A. regulation. This resolution was amended by changing the word "eight" to "twelve" in the last paragraph.

The committee recommends adoption of this resolution.

VICE-SPEAKER CHARNOCK: Is there a second?

A MEMBER: I second it.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report favoring adoption of the resolution as amended. Is there any discussion?

Those that are in favor of adopting this section of the report signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No. 17: Regarding Ambulances. The committee rejects this resolution on the grounds that it feels that the problem is outside the jurisdiction of C.M.A. It would seem that this is a problem of the State Highway Patrol and other law enforcement agencies.

The committee recommends the rejection of this resolution.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report which has the intent to reject the resolution. Is there any discussion on the question?

Those that are in favor of this section of the report will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No. 18: The intent of this resolution is to teach and train interns and residents about certain aspects of economic medicine after the manner of free enterprise. Otherwise we are likely to lose the newer generation of doctors to a collectivist ideology. The committee feels that this is a training problem that we should take advantage of. The committee feels that this problem is not within the province of present constituted committees.

The committee amends this resolution by changing the word "instructed" to the word "requested" in the second sentence of the last paragraph; and by introducing the phrase "if necessary" in the last sentence in the last paragraph following the phrase, "To this end."

The committee recommends the adoption of this resolution as amended.

VICE-SPEAKER CHARNOCK: Do I hear a second?

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report. Is there any discussion? All those in favor of this section of the report will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Resolution No. 19: The intent of this resolution is to point up the fact that many members of the C.M.A. and specifically members of the Fee Schedule Committee feel that they have not been able to get a proper hearing before, or action by, the Board of Trustees of C.P.S. This resolution is an effort to establish a coordinating body that was intended to resolve this difficulty.

The committee spent much time in listening to witnesses regarding this measure. The witnesses consisted of officers and delegates of the C.M.A.; trustees of the C.P.S.; legal counsel of C.P.S. and C.M.A.; as well as proponents and opponents of the resolution.

The committee feels, as a result of the hearings, that the resolution would not accomplish the intent desired; that adoption of this resolution would interfere with the existing effective liaison between C.M.A. and C.P.S. by introducing an unwieldy third element; and that it would interrupt the proper functioning of C.P.S. and would necessitate major constitutional changes in C.M.A., and in the Articles of Incorporation of C.P.S.

The committee respectfully suggests to the officers of the C.M.A. and to the Board of Trustees of C.P.S. that they recognize the existence of a problem, and further requests that study and action be engaged in to correct what appears to be an unsatisfactory situation.

The committee recommends rejection of this resolution.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report. Is there any discussion?

Dr. Bender.

DR. BENDER: I apologize for appearing before you once again, but this is just to keep the record straight. All of the committee's objections on a legal basis were removed before this resolution left the committee, by mutual agreement between the proponents and the members of the committee. I see that in spite of the agreement to remove certain objectionable factors, which I already pointed out to you in this report, that was not done in the printed forms that you received. So, I believe that the committee has not been exactly fair in making the changes the committee and proponents agreed upon when the committee makes its recommendations to you.

Now, the committee makes the recommendation and respectfully suggests that further studies be made of this subject.

I would like to ask the Chair if it is out of order to make a motion to that effect now.

For the benefit of the Chair I repeat that question. The committee feels as a result of the hearings that certain things should be done and they respectfully suggest to the officers of C.M.A. and the board of C.P.S. that they recognize the existence of a problem and further request that study and action be engaged in to correct what appears to be an unsatisfactory condition.

I ask the Chair whether or not I am out of order to make a motion toward that end at this time.

VICE-SPEAKER CHARNOCK: You may amend the report, that section of the report. You can put that in as an amendment. We will accept it as an amendment.

DR. BENDER: I make the following amendment to the report of the Reference Committee: That a committee of five members of the House of Delegates be appointed to make a study of the problem which the Reference Committee admits exists and that within six months it return its results, the results of its study on the advisability of resolving this weakness in the set-up of C.P.S., and that it make this report to the Council of the California Medical Association.

VICE-SPEAKER CHARNOCK: Is there a second to that amendment?

A MEMBER: I second the amendment.

VICE-SPEAKER CHARNOCK: The amendment is seconded. The vote is now on the amendment to that section of the report. Is there any discussion on that?

DR. JACOBS: I just want to say one word about the resolution. Dr. Bender said that the resolution is changed. However, you will notice on this mimeographed copy that Resolution No. 19 is in the exact wording as presented by Dr. Bender. There wasn't a word changed.

DR. LOOS: Mr. Speaker, I would like to ask this of Dr. Bender: I would like to have the record straight. Dr. Bender, in his report to you about the Resolutions Committee No. 3, stated that there had been an agreement arrived at between the committee and Dr. Bender regarding certain phases of this matter.

Now, I was there, and I did not hear any agreement made with anybody on this resolution or any other resolutions. Thank you.

VICE-SPEAKER CHARNOCK: Is there any more discussion?

DR. BENDER: I don't know whether you have the original of the resolution which was presented by us or not, but one of them was marked in purple ink by Dr. Jacobs' pen, showing the things that were crossed out by me in his presence, and in the presence of the other two members of the committee as the amended resolution which we were then presenting to the Resolutions Committee.

It is entirely the business of the Resolutions Committee as to whether or not they accept such changes or whether they accept the resolution or reject it. I am not interfering with that.

But the fact remains that we made certain changes in there in their presence, and I have no written agreement to the contrary notwithstanding. But, it seems to me, I got the impression that they believed that these corrections would be acceptable to the committee. As a matter of fact, certain of us who were there were told before we left that this resolution would be acceptable to the committee who subsequently changed their minds and left out the changes which we made.

VICE-SPEAKER CHARNOCK: As a point of information for the House, the mimeographed sheet is the stencil that has been cut just as the resolution was put in to the Reference Committee, and the Reference Committee's report is on the other mimeographed sheet.

The question is now on the amendment by Dr. Bender, which has been seconded; the appointment by the Council of five members of the House of Delegates to make a study of the problems connected with this section of the report.

Is there any further discussion on that amendment?

Those who are in favor of the amendment will signify by saying "aye."

. . . The motion was put to a vote. . . .

VICE-SPEAKER CHARNOCK: The Chair is in doubt. Those who are in favor will please stand up.

. . . A rising vote was taken on the motion. . . .

VICE-SPEAKER CHARNOCK: The amendment carries.

The question is now on the adoption of this section of the report as amended. Is there any further discussion?

Those in favor of this section of the report will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Under new and miscellaneous business, I wish to present the resolution that was read from the floor earlier this evening. In order to refresh your minds on it I will give you the resolve part of it. It was presented by Dr. Justin Stein.

Therefore be it

Resolved: That the President of the California Medical Association be instructed at this session to appoint a permanent Committee on Military Affairs, whose duties shall be to:

1. Establish liaison between the Medical Advisory Committee to the Secretary of Defense and the American Medical Association on all matters pertaining to the procurement and assignment of physicians.

2. Assist in the formulation of any legislation, if it should be required, to obtain physicians for the Armed Forces during peacetime.

3. Help establish proper quota of physicians for the Armed Forces during both peace and war time in the State of California.

4. Establish liaison between the various county medical societies of the state and keep them informed on all problems pertaining to the procurement and assignment of physicians.

5. To work with the Disaster Control Committee regarding the coordination of civilian disaster plans with those of the military during major disasters, such as fire, earthquake, atomic warfare, and so forth.

The committee has studied this over during the last hour or two and wishes to amend the resolution as follows:

The committee feels that this should be on a state level and not a national level as would be indicated in the resolution. The committee would add, in the third line of the paragraph beginning "Therefore be it resolved," these words: "whose duties with respect to the State of California," etc.

Then, the committee would change the word "physicians" to "medical services," in the paragraph numbered "2."

And in No. 3, it would delete "in the State of California," as being redundant.

Mr. Speaker, the committee recommends the adoption of this resolution as amended.

VICE-SPEAKER CHARNOCK: Do I hear a second?

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: Is there any discussion?

DR. THOMAS (Palo Alto): Because Resolution No. 3 and this one are somewhat conflicting and overlapping I see that either to withdraw one or the other is in order. Because there are a few more specific implications by this last resolution that are not included in Resolution No. 3 and because there are certain things covered in Resolution No. 3 that are not covered by this one, I believe that there should be an amalgamation of the two.

I don't believe either one of them should be thrown out, the reason for this being merely a surface show.

In other words, the intent of both is the same—to set up some sort of liaison between the medical profession and the military.

VICE-SPEAKER CHARNOCK: Is there any further discussion?

The question is on the adoption of this resolution as amended by the Reference Committee.

Those that are in favor will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. JACOBS: Mr. Speaker, members of the House, the committee recommends the acceptance of the report of Reference Committee No. 3 as a whole.

VICE-SPEAKER CHARNOCK: Is there a second?

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: The question is on the adoption of the report of the Reference Committee No. 3 as a whole, as amended.

Those in favor of adopting this report will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: The Chair wishes to thank Dr. Francis Jacobs, Dr. H. Clifford Loos and Dr. M. Laurence Montgomery for their work on this committee. (Applause.)

The next order of business is the report of Reference Committee No. 2 on reports of the Secretary-Treasurer and the Executive Secretary on Budget and Dues. Dr. Alson R. Kilgore, chairman.

REPORT OF REFERENCE COMMITTEE No. 2

DR. ALSON R. KILGORE: Mr. Speaker and members of the House of Delegates: Your Reference Committee, Stanley R. Truman of Alameda, Dr. G. Wendell Olson of Orange, and I, has considered the reports assigned to it by the speaker and submits for your consideration the following recommendations:

Report of the Secretary: Another year finds our Association more profoundly in debt to its members who serve as officers and on committees for the good of the cause and the love of their profession. It would be difficult to place them in the order of magnitude of their contribution but the Secretary stands high on the list. Your committee can only recommend a formal expression of thanks and appreciation from this body.

Mr. Speaker, I move the adoption of this section of the report.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded we adopt this section of the report. Is there any discussion?

Those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted. (Applause.)

DR. KILGORE: Report of the Treasurer: The Treasurer's financial statements are printed in full in the annual report bulletin and require no explanation by this committee.

Mr. Speaker, the committee moves the adoption of the Treasurer's Report.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: The question is on the adoption of this section of the report. Is there any discussion?

SEVERAL MEMBERS: Question.

VICE-SPEAKER CHARNOCK: Those that are in favor of the adoption of this section of the report will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. KILGORE: Report of the Executive Secretary: The Report of the Executive Secretary enumerates ten major activities ranging from that of general business manager to promotion agent. Some of these categories comprise numerous subdivisions such as serving as secretary for about two dozen standing and special committees, which he modestly admits he has done when invited. It appears to this committee he has been as busy as a small boy at a side show. Your Reference Committee appointed a subcommittee to study the report. The subcommittee got so tired just reading about all the work that he adjourned to the bar to restore his depleted tissues and the rest of the committee had to go down and catch him and bring him back.

The report contains little estimate of the quality of the job turned in, as indeed it does not need to. The quality speaks for itself. The Association is fortunate to have a man in this position who has made our interests so wholly his and who is able to spread himself so thin and yet be so effective. We recommend that the House express to John Hunton our appreciation, and our admiration and esteem.

Mr. Speaker, I move the adoption of this section of the report. (Applause.)

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. All in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. KILGORE: You have in your hands a copy of the proposed budget for 1949-1950. This varies from that proposed by the Council chiefly in the items of estimated income, and in the estimated balance between income and expenditures.

The Council's estimation of income is based on dues from approximately 10,000 members at $37. That means dues at $40 with $3 allocated to the CALIFORNIA MEDICINE, making a net to the Association of $37.

This item would be $372,000. On this basis operations for the year with expenses as estimated would result in a deficit of $31,500. Your committee believes that the estimate of 10,000 members is perhaps a little optimistic. It is our understanding that there are, of this date, 9,600 members.

Some new members are to be expected during the year, but it is to be remembered that members joining after mid-year pay half dues. Is that correct?

EXECUTIVE SECRETARY HUNTON: Correct.

DR. KILGORE: It seems to our committee that 9,750 members would be a safer estimate, in which case the deficit of $31,550 would be increased by $9,250 to a deficit of $40,800.

First, about the desirability of deficit financing with reference to the combined balance. If you have your convention bulletin and will turn to page 16 in the Annual Reports, the top table on the page, third column, you will find that the combined surplus of the C.M.A. and Trustees is set down as of June 30, 1948, as $1,155,231.65.

On the proposed budget sheet you will find shown a balance from 1948-1949 operations estimated at $105,195. Presumably this will be added to the above surplus, making a total surplus at the end of this fiscal year of $1,260,426. That is roughly a little over one and a quarter million.

Your committee believes that dues should be reduced rather than added substantially to this surplus, but we do not believe that it would be sound to start cutting the surplus down for current operating expenses.

The proposed estimates of various expenditures as shown on this sheet you have in your hands have been made on what is believed to be a liberal basis, and that actual operations cost will prove to be sufficiently less than estimates in many instances, so that a separate item for contingencies has not been included.

Certain items in the budget deserve a little special comment. First, Item No. 11, American Medical Association meeting expense. The House passed the resolution earlier this evening to pay the expenses of alternates as well as delegates and this will in an ordinary year substantially increase the cost incurred but will not be so effective this next year because the meeting will be in San Francisco.

The delegation has, however you should remember, been increased by one and by one alternate. The figure $15,000 shown is believed to be a reasonable and liberal estimate for that.

Cancer Commission, Item No. 17, shown in the budget a year ago at $5,000. This year it is estimated at $6,000. The estimated budget request is for $25,000. This is substantially increased because it is expected during next year a series of cancer commission articles will be completed in handbook form and distributed to the membership, and also because of the action of the Council in taking over from the government certain expenses in connection with the cancer seminars that are being held throughout the state.

No. 3, Department of Public Relations, Item No. 16. Earlier this evening in a resolution that you adopted you implied at least a continuation of the public relations program, substantially as it has stood. This includes as its major item of expense the "California Caravan" program and your committee agreed in advance with a decision this House had taken tonight. That is, after all, a very major item and if you will bear with me for two or three minutes I think we ought to take back to our constituents a little more extended explanation than was given earlier this evening.

The committee found when we got together that we had all come to Los Angeles with the feeling that "California Caravan" ought to be discontinued as an expensive and unnecessary luxury, for two reasons. In the first place, we think the show is lousy. If I remember correctly, a considerable number of delegates a year ago expressed that same opinion in no uncertain terms.

In the second place, because it has served its purpose, the main fight against socialized medicine is now on a nationwide basis rather than here in California, although I think your Public Policy and Legislative Committee chairman will tell you it is by no means abated yet in California.

Now, we would like to change our minds after consultation with a number of people including Mr. Clem Whitaker, whose attitude was that "California Caravan" should be kept or rejected exactly as you saw fit, that it doesn't mean a major item in his national campaign at the present time.

He did want to point out certain aspects of it. In the first place, whether we like it or not ourselves, whether we think the show is corny, it does have a wide listening appeal. We are not trying to reach other members of the House of Delegates. We are trying to reach stenographers and housewives who vote just as heavily as we do, and the Hooper rating pretty consistently shows that this radio broadcast has an audience of around half a million people in California, many of them steady customers.

I asked Mr. Whitaker if it was not so that in general radio programs tend to run out, so to speak, go to seed, lose their appeal, and he said, "Certainly, that is true, but it isn't true yet of 'California Caravan,' and the Hooper rating figures comparing last year with this year show that."

If I remember the figures he had, during January, February and March the Hooper rating in all three

months of 1948 was in the neighborhood of 4.0. The rating in January of 1949 was 4.6; in February, 4.0; in March, 4.9.

So, on the whole this year it has a 15 to 20 per cent wider appeal and greater effectiveness than it had a year ago. It is not necessary to use it for any one continuing purpose. If we feel that it has contributed the major part to the job of the explanation of California Physicians' Service at the time that explanation was needed and that we do not need it for continued expansion of C.P.S., it can be devoted to anything else we want to devote it to.

We can devote it to our defense against the next attack made on us in California. We can expect those with recurrent regularity. We can use it in the meantime to sell organized medicine, both California organized medicine and national, to publicize the services of organized medicine to the people of this country and so build up good will for organized medicine.

Finally, if we discontinue "California Caravan" at the present time, we give up a property which we cannot get back. We own the title to this show as long as we want to continue to use it, but once we have given it up, it is our understanding that it can be sold to any commercial sponsor that wants to accept it, and the presumption is that it wouldn't find much difficulty in finding a sponsor, and then we would not be able to get it back. We would also have lost the regular spot on the air.

We asked about the possibility of cutting down the expenses by reducing the time and were surprised to find cutting the time in half from 30 minutes to 15 minutes would reduce the cost of the radio time only about 20 or 25 per cent and would actually increase the cost of trying to prepare the program, because of the difficulties of condensing it to a 15-minute program.

So, your committee feels, as obviously this House of Delegates does, that this should be continued. The expenses of "California Caravan" are estimated on the basis of this year's expenses at approximately $88,000 for radio time and preparation of the show, and an additional $20,000 for newspaper advertising of the radio program.

Those figures are included in the total item in the proposed budget of $149,000 for the Department of Public Relations.

Now, your committee in considering this felt it was doubtful if the newspaper advertising contributed enough to the value of this show to justify a continuance of at least as much as $20,000 expenditure. We don't know. Perhaps there is no way of knowing until you experiment. We therefore recommend that the newspaper advertising be discontinued, at least on an experimental basis for 30 to 90 days, and see what happens to the Hooper rating. If it doesn't deteriorate the Hooper rating too much, conserve that $20,000, which is in itself sufficiently large to be a contingent item.

The budget as presented, therefore, comes up finally with a deficit in the lower right-hand corner of the page of $450, which, if our estimates are anywhere near correct, is substantially even.

This contemplates dues of $45 less $3 allocated to CALIFORNIA MEDICINE, and it is your committee's recommendation that the dues for the ensuing year be set at this figure.

Mr. Speaker, I move the adoption of this section of the committee's report.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded we adopt this section of the committee's report. Is there any discussion? If not, all those who are in favor of the adoption of this section of the report will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted.

DR. KILGORE: Mr. Speaker, I move the adoption of the report as a whole.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we adopt this report as a whole. Those that are in favor of this adoption will signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

VICE-SPEAKER CHARNOCK: It is adopted as a whole. And the Chair thanks Dr. Alson Kilgore, Dr. Stanley R. Truman and Dr. G. Wendell Olson for their work in this behalf. (Applause.)

Announcements by the Secretary.

SECRETARY GARLAND: The Treasurer would like to state that when Dr. Smith of San Diego informed the San Diego delegates that dues for the next year would be $40, he did so in good faith. The Council thought that would be the approximate figure. We now see it is $45, and we apologize for the error.

VICE-SPEAKER CHARNOCK: Before we turn this meeting over to Dr. Alesen, we should thank Reference Committee No. 4, J. Norman O'Neill, A. A. Morrison, and Dr. Dave F. Dozier. They had nothing to do but they stood by.

SPEAKER ALESEN: Mr. Secretary, is there any old unfinished business?

SECRETARY GARLAND: Mr. Speaker, there is no old unfinished business on this docket.

SPEAKER ALESEN: Dr. Bruck.

DR. BRUCK: Was there not a report that was to be given to the House of Delegates by Dr. Cass on unfinished business?

SPEAKER ALESEN: Report by Dr. Cass.

DR. CASS: Mr. Speaker, members of the House, this report is in the nature of a follow-up report on the Industrial Accident Schedule. It is not a formal report because there is nothing formal to report. We had two meetings in the south with representatives of insurance companies elected by the insurance companies, and the meeting in the north with a statewide committee to try to assure the insurance

representatives that we were not slamming the door in their face, not refusing them a chance to consider our new industrial accident schedule, not trying to stuff it down their throats.

As you know, before that insurance companies had refused to meet with us formally and we were left on the end of the springboard. We had to produce a fee schedule because we were notified by the Industrial Accident Commission that the old schedule would become ineffective as of June 30. The Commission recommended that we get together with insurance companies and figure out a fee schedule of our own which the Commission would consider according to the Workmen's Compensation Act and adjudge the claims in dispute.

When we tried to meet with the companies, they refused to meet formally and said they didn't object to doctors getting an increase in fees, but they objected to doing it formally because it would look like they were crossing up their insured, and they didn't want to be a party to raising the rates of insurance. So we went ahead and got our own fee schedule. You all got copies of it. As the companies still refused to meet with us, the Council sent you letters to ask you to put your new fee schedule into effect as of the first of February.

But we would not be able to enforce the new fee schedule or have hearings on it until after the 30th of June because the Commission had given us a little double talk, saying first of all they didn't have the authority to produce a fee schedule or recommend one, but they would continue the one they had already put into effect until next June 30. So we know if we would try to dispute our new fee schedule between now and June 30, the Commission would be in the position of having to refute its own fee schedule, the one that they say is the one for the next six weeks.

So, we were in a kind of impasse, and many of the members were disappointed to think that the Council hadn't backed them up, but as a matter of fact the insurance companies came to life all of a sudden when they found we actually had a fee schedule and were impatient to get together with us and thought we had done things without consulting them officially.

So, we contacted the insurance companies, got their committees organized, met twice in Los Angeles only to have the insurance companies tell us that the Los Angeles Commission wasn't official, that the official commission was statewide and to meet in San Francisco.

We went there and had a very good meeting. By the way, the committee that met with the insurance carriers was a second or separate committee of the Council of C.M.A., and our committee was Dr. Ball and Dr. Johnson, and two doctors of the Industrial Accident Commission, who assured us they think our fee schedule is exactly right, and they are going to back it up after June 30.

But, at the present time the only result of our meeting was a statement from the insurance companies that they wish to prepare a criticism or a new fee schedule to submit to us, that they had some ideas about submitting certain fees in one single total fee for procedures such as amputation of a finger or hernia, and they felt a flat fee would be better than a fee paid for visits.

We assured them we were not interested in reducing our schedule at all. Whatever fee they presented as a flat fee would be the same we would get if the same service were done under our schedule.

They promised to have a report for us immediately. Nothing happened.

Last Monday, John Hunton, in order to get a report for this House of Delegates, contacted them and asked them what they were going to do and they said they would have a report within a week. Then he asked them would they please write to the committee and tell them that.

I got a letter just a few days ago which was from the chairman of their committee, and they stated they were working on a fee schedule which they wished to present to us as soon as they could get it together.

Well, now, I don't believe they are going to present a fee schedule to us at all. I think they are just stalling, but that is only my opinion.

But the Council in this meeting this morning felt that it would be an expediency that we couldn't overlook in order to make this thing come to a head by the 30th of June that we would contact this committee again, that I would answer the letter and tell them that we will give them until the first of June, and if we don't have anything forthcoming by then we assume they are not going to do anything about it, and we insist our fee schedule be effective on July 1.

So, all of the members of the California Medical Association will get a letter from the Council some time after June 1, which I believe will say that after the first of July the services of our legal counsel are at your beck and call to enforce our fee schedule, and I am sure that when the first of July comes along we will not have very much opposition from the insurance companies, because already many of our members are getting paid right now under the new fee schedule.

It might be interesting to you all to know that a very short time ago—not more than six weeks ago—Mr. Gallagher, the manager of the State Compensation Insurance Fund, made his annual report to Mr. Scharenberg, head of that group of the committee of the state, and in this report he very proudly showed that the state fund increased its backlog of finance by two and a half million dollars, and had been able to make a return premium or dividend to their subscribers or members of 30 per cent of the premium.

If they have that kind of money it seems to me the only way an insurance company could make dividends available would be by accident prevention and not by sweating the dough out of the doctors.

So, I think we are pretty safe in saying there will be no valid arguments to keep our fee schedule off the books after the first of July. (Applause.)

SPEAKER ALESEN: Dr. Cass, is there any action you suggest on this report, or is this just informative?

DR. CASS: I believe the letter from the Council will be forthcoming after the first of June. It doesn't require any action.

SPEAKER ALESEN: Thank you.

Mr. Secretary, is there any further old unfinished business?

SECRETARY GARLAND: Dr. Bruck, is there any additional business? (Laughter.)

SPEAKER ALESEN: The Chair at this time under the subject of new business requests the consent of the House to invite Dr. John Cline to present a resolution for the good of the order. Dr. John Cline needs no introduction to this House.

DR. CLINE: Thank you, Mr. Speaker.

In the interest of keeping the record straight I shall ask that someone else introduce this resolution because I am no longer a member of the House. (Laughter.)

The resolution is as follows:

Resolved: That the House of Delegates of the California Medical Association express to the President of the United States, the Federal Security Administration, the Senators and Members of Congress from California that the California Medical Association is opposed to the socialized medical program proposed by the President for the following reasons:

1. It would result in damage to the medical care, health and welfare of the people of this country.

2. It would regiment the people and the medical profession of this country.

3. It would impose an additional heavy burden of taxation upon all the people.

4. The problems of distribution of medical care are in the process of orderly solution. The ultimate complete solution of these problems can be accomplished without resort to socialistic measures. (Applause.)

SPEAKER ALESEN: Just to keep the technical record straight, will someone move the adoption of that?

DR. WARD: Could I have that honor?

SPEAKER ALESEN: Would you like to speak on the resolution while you move its adoption?

DR. WARD: Mr. Speaker and members of the House of Delegates, I take great pleasure in introducing the resolution just read to you by Dr. Cline, with gusto. I regret that Ed Bruck didn't have the chance to do it. It is because I spoke a little faster than he did.

I move the adoption of this resolution.

DR. BRUCK: I second the motion.

SPEAKER ALESEN: Is there a discussion?

If not, all those in favor signify by saying "aye."

. . . The motion was put to a vote and was carried. . . .

SPEAKER ALESEN: Mr. Secretary, will you record it that the adoption was by unanimous vote.

SECRETARY GARLAND: It is recorded.

SPEAKER ALESEN: Is there any other new business to come before the House at this time?

SECRETARY GARLAND: No other business.

SPEAKER ALESEN: At this time, members of the House of Delegates, it is my good pleasure to present to you your new President, Dr. R. Stanley Kneeshaw. He is not unknown to you. (Standing applause.)

PRESIDENT KNEESHAW: Thank you Mr. Speaker. Members of the House of Delegates and guests, as I accept this honor to become your President, I stand awed by the magnitude of the problems that present themselves to us today. At no time in our history has our profession been so threatened by politicians, social workers and do-gooders.

We have witnessed the fall of medicine in England to a low ebb because of disunity of the medical profession and unpreparedness of that profession to defend itself against the politicians.

Are we to stand idly by here in the United States and let that same thing happen to us? We must be united in our efforts and if we can but rally our members to be loyal to stand by our leaders, to be willing to sacrifice and give unstintingly of their time to carry our message to the people, we have nothing to fear.

If you delegates to the C.M.A. assembled here can act in your own communities to radiate that energy, activate the other members of our local societies to get these messages over, we can succeed.

We must be willing to sacrifice our time and our money in order to protect the people of these United States from the catastrophe that would befall them should this socialized medicine be instituted in these United States.

Because we in California have had a good deal of experience in combatting this socialized medicine we might perhaps be called upon to assist in combatting this type of legislation on a national level. We, therefore, must be prepared.

So let us put aside any petty grievances that we may have, be united as never before, keep our own house clean, make no mistakes in our good patient relationship so we in California can be proud of our efforts.

I want you to know that I well realize the tremendous affection that you and I have for Dr. Vince Askey who has done so much for us in the past, and I don't ever expect to attain such a position in your affections. I know I feel like any sprinter who tries to catch up to Mel Patton in the 100-yard dash, but I want you to know I will try to do a very good job.

So, once again, ladies and gentlemen, I wish to thank you for having had enough confidence in me to elect me to this high office. I know there will be many problems that will be difficult to solve, and I want to ask your aid in solving them, and that God give me the strength and wisdom to properly carry

out the responsibility imposed upon me in accepting this honor. Thank you. (Applause.)

Now, my first official duty is to present to you a man that needs no introduction. I have been in this society long enough to have seen all the speakers of the House that you have had before you—Ed Pallette, Dr. Roblee, Dr. Lowell Goin, Vince Askey, and now again Louie Alesen.

These fellows, it seems, are all outstanding men and I would like to have the opportunity here and now to give my approbation to this little rascal who heads you up here all the time. (Standing applause.)

Now, my next task is to the guy who got me into this mess. I surely wouldn't be here tonight if it wasn't for this fellow. May I have somebody escort this gentleman up here—Donald Cass. Will you two gentlemen kindly escort that gentleman over there. (Standing applause.)

DR. CASS: Well. I want to thank you. I didn't prepare a speech because it is a big surprise to be elected. (Laughter.)

But I feel just like Stanley does, following a bunch of Babe Ruths and Ty Cobbs and Goins and Askeys, and McClendons, and high class Presidents. I doubt if I can keep up their speed, but I will try as hard as I can. (Applause.)

PRESIDENT KNEESHAW: I next have the pleasure of presenting your Vice-Speaker. I have always been on this Council as Don has, and he has done a fine job. Don. (Standing applause.)

VICE-SPEAKER CHARNOCK: At this hour, silence is golden. (Applause.)

PRESIDENT KNEESHAW: Now I would like to call upon one of our ex-presidents here. Where is John Cline now?

John, would you kindly come up here? You have a job to perform.

DR. CLINE: The job which is mine is indeed a pleasant one. It is pleasant for more reasons than one. As Stanley so well told you, the affection, the regard in which Vince Askey has been held by all those who worked with him—I must say that doubly do I have those sentiments toward him, because of my strong personal friendship for him as well as my admiration and respect for the things he has done in medicine. And because a year ago at this time I felt the relief of the burden falling from my shoulders and for the first time since I have been an active member of this House was it possible for me to have two meals with my wife in one day, I know that Vince is going to feel the same way; that he has done his job and that he now has earned a measure of relief.

But beyond that it is a great pleasure for me to be able to extend to him a token of appreciation of this Association for all that he has done for it. Vince, this plaque which the Association now presents to you, I hand you with every best wish. (Standing applause.)

EX-PRESIDENT ASKEY: Ladies and gentlemen, I think that all men come to the end of a pleasurable journey with some degree of regret. But the knowledge that the memory can be recreated—all the thrills of that journey—assuages to some extent the regret that you feel.

My journey as your President has been pleasant indeed. But this has been true only because you were my companions and because I had a loyal understanding wife at my side. May I wish for the continued success and progress of our Association, and I bespeak for you, Stanley, loyal support to Stanley Kneeshaw.

I thank you from my heart and I will long treasure this token which you presented to me. Thank you. (Applause.)

SPEAKER ALESEN: Mr. Secretary, is there any further business to come before the House before adjournment?

SECRETARY GARLAND: Mr. Speaker, there is the matter of the approval of the minutes.

SPEAKER ALESEN: As customary, a committee is appointed for that purpose. Will the House concur? Hearing no objection, the House is assumed to concur. Is there any further business?

Does any member have anything for the good of the order? If not, the motion to adjourn is in order.

A MEMBER: I so move.

ANOTHER MEMBER: I second it.

. . . The motion was put to a vote and was carried.

The meeting of the House of Delegates of the California Medical Association adjourned at 11:45 p.m.

Council Meeting Minutes

359th Meeting

Tentative Draft: Minutes of the 359th Meeting of the Council, Los Angeles, Saturday, May 7, 1949.

The meeting was called to order by Vice-Chairman Sidney J. Shipman in Conference Room No. 5 of the Biltmore Hotel, Los Angeles, at 10:00 a.m., Saturday, May 7, 1949.

Roll Call:

Present were President Askey, President-Elect Kneeshaw, Speaker Alesen, Vice-Speaker Charnock, Councilors Ball, Crane, Henderson, Anderson, Ray, Lum, Green, Cherry, MacLean, Hoffman, Shipman, Bailey and Thompson; Secretary Garland and Editor Wilbur.

Absent: Edwin L. Bruck and Wayne E. Pollock (illness).

Present by invitation were Legal Counsel Hassard, Executive Secretary Hunton, County Society Executive Secretaries Donovan of Santa Clara and Waterson of Alameda, Messrs. Clem Whitaker, Sr., Clem Whitaker, Jr., and Ned Burman of Public Relations Counsel.

1. *Minutes:*

(a) Minutes of the 358th meeting of the Council, held March 5-6, 1949, were approved.

(b) Minutes of the 214th meeting of the Executive Committee, held March 6, 1949, were approved.

2. *Membership:*

(a) A report of membership as of April 30, 1949, showing 9,319 active and 381 delinquent members, was received and ordered filed.

(b) On motion duly made and seconded, one member delinquent for 1947 and 1948 was voted reinstatement as an active member.

(c) On motion duly made and seconded, 1,264 members whose 1949 dues had been received since April 1, 1949, were voted reinstatement as active members.

(d) On motion duly made and seconded in each instance, 15 applicants were voted election to Associate Membership. These were:

James W. Ellis, Alameda County.
Edward Kupka, Alameda County.
Evelyn F. Buchheim, Fresno County.
Richard Argens, Napa County.
R. G. Berendsen, Napa County.
Karl A. Reed, Napa County.
Reginald S. Rood, Napa County.
Max Berger, San Francisco County.
J. L. E. Brindamour, San Francisco County.
Emanuel S. Cohen, San Francisco County.
Manuel Weber, San Francisco County.
Joseph Thomas Nardo, Santa Barbara County.
Jean Swain, Santa Clara County.
Rutherford O. Ingham, Santa Cruz County.
Stanley J. Smiley, Yuba-Sutter-Colusa County.

(e) On motion duly made and seconded in each instance, B. M. Marshall of Humboldt County and Frank J. Leavitt of Los Angeles County were voted election to Life Membership.

(f) On motion duly made and seconded in each instance, six applicants were voted election to Retired Membership. These were:

C. C. Campbell, Los Angeles County.
H. C. Smith, Los Angeles County.
H. O. Howitt, Marin County.
Raymond L. Johnson, Riverside County.
Herbert S. Thomson, San Francisco County.
LaVerne Wright, San Francisco County.

(g) On motion duly made and seconded in each instance, six applicants were voted to Affiliate Membership. These were:

William Creger, San Francisco County.
Wallace G. Elliott, San Francisco County.
Mary Gulbransen, San Francisco County.
M. Glenn Molyneaux, San Francisco County.
Edward Weinshel, San Francisco County.
C. Dwight Yates, San Francisco County.

(h) On motion duly made and seconded in each instance, 27 applicants were granted a reduction of dues because of postgraduate study or protracted illness.

(i) Correspondence with Dr. Richard F. Mogan of Los Angeles County was read, in which he stated that he was still in the practice of medicine and was not desirous of remaining as a Retired Member, as voted by the Council at the last previous meeting. It was pointed out that the Los Angeles County Medical Association has rescinded its action in voting him into Retired Membership, and on motion duly made and seconded, the Council voted to rescind its earlier action in electing Dr. Mogan to Retired Membership.

(j) It was pointed out that there are considerably more licensed physicians in California than are represented by the Association's membership roster and it was regularly moved, seconded and voted that the Committee on Organization and Membership be requested to investigate any reasons why more of these licentiates are not members.

(k) On motion duly made and seconded Dr. Franklin Brundage of Santa Barbara County was granted a reduction of dues for military service.

3. *Financial:*

(a) A report of bank balances as of April 30, 1949, was received and ordered filed.

(b) A balance sheet as of April 30, 1949, was received and ordered filed.

(c) A statement of income and expenditures for April and for the ten months ended April 30, 1949, was received and ordered filed.

4. *Medical Society of the State of California:*

Discussion was held on the continuing confusion in the minds of many members between the Association and the Medical Society of the State of California. On motion duly made and seconded, it was voted that the Executive Committee be instructed to meet with the Board of Trustees of the latter organization and attempt to work out a clarification of the organization's name, eliminate any possible confusion and report back to the Council at a later meeting.

5. *Meeting Place for 1950:*

Discussion was held on possible meeting places for 1950 and it was reported that invitations had been extended by Los Angeles, San Francisco, Palm Springs, San Diego, Santa Cruz and Santa Barbara. On motion duly made and seconded, it was voted to hold the 1950 Annual Session at Los Angeles. [NOTE: At the Council meeting of May 11, 1949, reconsideration was given and San Diego chosen as the 1950 meeting place.]

6. *Cancer Commission:*

(a) A letter of complaint, alleging exclusion of certain physicians from a cancer seminar sponsored, among others, by the Cancer Commission, was read and discussed. It was pointed out that specific invitations to this seminar had not been issued and that no physicians were excluded.

(b) It was regularly moved, seconded and voted unanimously that the Council request Dr. Lyell C. Kinney to continue as a member and chairman of the Cancer Commission.

7. *National Emergency Medical Service:*

A letter from Louis Johnson, Secretary of Defense, was read, in which he asked the Association

to cooperate in securing voluntary recruitment of additional medical officers for the armed forces. The Secretary was instructed to make the need for medical officers known to the county medical societies and to solicit their aid in meeting the recruitment objective, subject to any instructions on this point which might be issued by the House of Delegates.

8. *Legal Department:*

(a) Mr. Hassard reported on a malpractice case which has recently been decided by the State Supreme Court, which has referred the case back to the trial court for further hearing. The case involves the principle of a general practitioner being required to possess the degree of skill ordinarily expected only in a medical specialist.

(b) Mr. Hassard reported on another malpractice case, where unsterile instruments were allegedly used and where Appellate Court had found to that effect, despite expert testimony and a jury verdict to the contrary. It was regularly moved, seconded and voted that the Association request the legal counsel to ask the Supreme Court for permission to appear as *amicus curiae.*

9. *Order of Business of House of Delegates:*

Speaker Alesen of the House of Delegates requested authority from the Council to change the order of business of the first meeting of the House in order to permit the delivery of a report on public relations by Mr. Whitaker. It was regularly moved, seconded and voted to approve this change.

10. *Public Relations:*

Mr. Whitaker spoke briefly on the progress of the A.M.A. public relations campaign and presented a proposed budget for the Association's 1949-1950 fiscal year. It was agreed to refer this budget to the Auditing Committee and the chairman of the Committee on Finance of the House of Delegates for consideration with the Association's complete 1949-1950 budget.

11. *California Physicians' Service:*

Drs. Chester L. Cooley and Donald Cass, Secretary and Trustee, respectively, of California Physicians' Service, appeared before the Council and reported: (1) that a new form has been developed to aid the physician in securing data for the determination of income ceilings; (2) that the Board of Trustees has approved a new fee schedule developed by a special fee schedule committee; (3) that C.P.S.'s financial condition is good, with more than $1,000,000 in reserves; and (4) that C.P.S. now has nearly 7,000 indivdual contracts in force and is considering an advertising campaign to increase this number.

12. *Employees' Retirement Program:*

Dr. Charnock placed a suggested employees' retirement program before the Council. On motion duly made and seconded, it was voted that his committee continue its studies and report back to the Council at a later meeting.

13. *Time and Place of Next Meeting:*

It was regularly moved, seconded and voted to hold the next meeting of the Council at 7:30 a.m., Sunday, May 8, 1949, in Conference Room No. 6 of the Biltmore Hotel, Los Angeles, and to continue daily meetings at the same hour through Wednesday, May 11, 1949.

Adjournment.

360th Meeting

Tentative Draft: Minutes of the 360th Meeting of the Council, Los Angeles, Sunday, May 8, 1949.

The meeting was called to order by Vice-Chairman Shipman at 7:30 a.m., Sunday, May 8, 1949, in Conference Room No. 6 of the Biltmore Hotel, Los Angeles.

Roll Call:

Present were President Askey, President-Elect Kneeshaw, Speaker Alesen, Vice-Speaker Charnock, Councilors Shipman, Ray, Anderson, Bailey, Henderson, Green, Lum, MacLean, Ball, Crane, Cherry and Thompson; Secretary Garland and Editor Wilbur.

Absent: Edwin L. Bruck and Wayne E. Pollock (illness).

Present by invitation were Dr. D. H. Murray, chairman of the Committee on Public Policy and Legislation; Dr. Donald Cass, Trustee of California Physicians' Service; Executive Secretary Hunton, Legal Counsel Hassard, Dr. Wilton L. Halverson, State Director of Public Health; Mr. Frank Kihm, executive secretary of the San Francisco County Medical Society; and Messrs. Clem Whitaker, Sr., Clem Whitaker, Jr., Ned Burman and James Dorais of Public Relations counsel.

1. *Budget for 1949-1950 Fiscal Year:*

Discussion was held on a suggested budget for the 1949-1950 fiscal year, subject to review and approval of the House of Delegates. An item for public relations for the year, suggested by Mr. Whitaker, was approved and ordered included in the budget. Dues of $40 for the calendar year 1950 were approved, and the entire budget was ordered submitted to the House of Delegates for review by the Committee on Finance and approval by the House.

2. *State Department of Public Health:*

Dr. Wilton L. Halverson, State Director of Public Health, discussed the problems confronting the hospital bureau of his department in the allocation or approval of state and federal funds for aid in hospital construction. He stated that the rule-of-thumb in the bureau was to deny the allocation of funds in areas where a county hospital contained one-third or more of the beds in the area. He also told of the difficulties involved in allocating funds as between

two or more eligible hospitals in the same area. He requested that a committee of two or three members, representing the Association, be appointed to advise with this department on these and similar matters.

3. *C.M.A. Statement of Policies:*

A proposed statement of policies of the Association in regard to health care and extension of medical service was discussed and, after amendment, was, on motion duly made and seconded, adopted. [This statement was printed on page 504 of the June issue of CALIFORNIA MEDICINE.]

4. *Approval of Other Organizations:*

Discussion was held on the bases for Council approval of various organizations operating in the field of health care and it was regularly moved, seconded and voted that this matter be referred back to a special Council committee for further study and report back to the Council.

Adjournment.

361st Meeting

Tentative Draft: Minutes of the 361st Meeting of the Council, Los Angeles, Monday, May 9, 1949.

The meeting was called to order by Vice-Chairman Shipman at 7:30 a.m., Monday, May 9, 1949, in Conference Room No. 6 of the Biltmore Hotel, Los Angeles.

Roll Call:

Present were President Askey, President-Elect Kneeshaw, Speaker Alesen, Vice-Speaker Charnock, Councilors Green, Bailey, Hoffman, Henderson, Anderson, MacLean, Lum, Ball, Ray, Thompson, Shipman and Crane; Secretary Garland.

Absent: Edwin L. Bruck and Wayne E. Pollock (illness).

Present by invitation were Legal Counsel Hassard, Executive Secretary Hunton, Assistant Executive Secretary Wheeler, Dr. D. H. Murray, chairman of the Committee on Public Policy and Legislation; county society executive secretaries Kenneth Young of San Diego and Rollen Waterson of Alameda, and Messrs. Clem Whitaker, Jr., and Ned Burman of Public Relations Counsel.

1. *Merced County Hospital Situation:*

Drs. James L. Dennis of Merced and George B. Pimentel of Los Banos appeared by invitation before the Council and discussed the hospital situation in the city and the county of Merced, where the county hospital is reportedly in line for approval of state and/or federal funds for construction of an addition and where private cases are reportedly being treated by county-employed physicians, while a private nonprofit hospital in the area has been denied approval of government funds for additions.

Dr. Wilton L. Halverson, State Director of Public Health, appeared and discussed this situation, asking the assistance of the Association in working out this and similar problems facing the hospital bureau of his department.

On motion duly made and seconded, it was voted that the Field Secretary be instructed to proceed to Merced at the earliest practicable date to review the situation there and to make recommendations to the local physicians and to the Council.

Adjournment.

362nd Meeting

Tentative Draft: Minutes of 362nd Meeting of the Council, Los Angeles, Tuesday, May 10, 1949.

The meeting was called to order by Chairman Bruck at 7:30 a.m., Tuesday, May 10, 1949, in Conference Room No. 6 of the Biltmore Hotel, Los Angeles.

Roll Call:

Present were President Askey, President-Elect Kneeshaw, Speaker Alesen, Vice-Speaker Charnock, Councilors Ball, Crane, Henderson, Anderson, Ray, MacLean, Bruck, Cherry, Green, Hoffman, Bailey, Shipman, Lum and Thompson; Secretary Garland and Editor Wilbur.

Absent: Wayne E. Pollock (illness).

and Hiram D. Newton of the San Diego County

Present by invitation were Dr. D. H. Murray, chairman of the Committee on Public Policy and Legislation; Drs. Clarence Rees, William B. Black and Hiram D. Newton of the San Diego County Medical Society; Legal Counsel Hassard, Messrs. Clem Whitaker, Sr., Clem Whitaker, Jr., and Ned Burman of Public Relations Counsel, and Mr. Rollen Waterson, executive secretary of the Alameda County Medical Association.

1. *Standing Committee Appointments:*

Nominations for three-year appointments to standing committee membership were presented by the Council's committee and, after discussion were duly approved for announcement to the House of Delegates. These nominations were:

Committee on Associated Society and Technical Groups—J. Norman O'Neill, Los Angeles.

Committee on Health and Public Instruction—George M. Uhl, Los Angeles.

Committee on History and Obituaries — E. T. Remmen, Glendale.

Committee on Hospitals, Dispensaries and Clinics —John Sharp, Salinas.

Committee on Industrial Practice—Jerome W. Shilling, Los Angeles.

Committee on Medical Defense—H. Clifford Loos, Los Angeles (chairman).

Committee on Medical Economics—Arthur A. Kirchner, Los Angeles.

Committee on Medical Education and Medical Institutions—Francis Scott Smyth, San Francisco.

Committee on Membership and Organization—Verne G. Ghormley, Fresno.

Committee on Postgraduate Activities—Charles A. Broaddus, Stockton.

Committee on Publications—Keene O. Haldeman, San Francisco.

Committee on Public Policy and Legislation—Peter Blong, Alhambra.

Committee on Scientific Work—Clayton Mote, San Francisco.

2. *San Diego County Medical Society:*

Drs. Rees and Newton discussed with the Council the request of the San Diego County Medical Society for the assignment of public relations counsel to the San Diego area and other matters of mutual interest. Mr. Waterson discussed a study of the public relations situation in San Diego County which he had made at the request of the Council chairman; this study was received with the thanks of the Council and ordered made a part of the county society file.

3. *Meeting Place for 1950 Annual Session:*

Dr. Rees extended the invitation of San Diego for the 1950 Annual Session meeting place. It was regularly moved, seconded and voted that the decision of May 7 to hold the 1950 Annual Session in Los Angeles be reconsidered. It was agreed to reconsider this matter at a recessed meeting of the Council the afternoon of May 10.

4. *Public Policy and Legislation:*

Discussion was held on two physical therapy bills now before the Legislature and it was regularly moved, seconded and voted that the measures proposed by Senator Breed and Mr. Levering be approved in principle, with discretion granted the Committee on Public Policy and Legislation to approve such amendments as may be desirable.

5. *Recess:* At this point the Council voted to recess until 3 p.m.

6. *Reconvention Following Recess:*

On roll call at 3 p.m., all the officers and Councilors noted present at the morning session were present. Also present were Messrs. Hunton, Hassard, Waterson, and Kihm.

7. *Industrial Fee Schedule:*

Discussion was held on possible progress in negotiations between the Association and the insurance carriers relative to adoption of a new schedule of fees for industrial injury cases. Dr. Donald Cass, chairman of the Committee on Industrial Practice, reported on preliminary meetings with insurance representatives and it was agreed that June 1, 1949, should be fixed as the latest date at which a reply from the insurance carriers might be received if Association members were to receive proper notification of the Council's recommendations.

8. *California Physicians' Service:*

Dr. Donald Cass, as a Trustee of California Physicians' Service, reviewed discussions of the past year relative to formation of a national insurance company or membership enrollment organization for members of Associated Medical Care Plans, of which C.P.S. is a member. He expressed his own approval of the formation of such an organization and asked that the Council express its approval for the guidance of C.P.S. Trustees in their consideration of this matter. This request was discussed and it was agreed to defer action at this time.

9. *Blood Banks:*

The question of the Association's offering financial support to community type blood banks was discussed and it was regularly moved, seconded and voted to invite Dr. John Upton, chairman of the Blood Bank Commission, to the next Council meeting.

Adjournment.

363rd Meeting

Tentative Draft: Minutes of the 363rd Meeting of the Council, Los Angeles, Wednesday, May 11, 1949.

The meeting was called to order by Vice-Chairman Shipman at 7:30 a.m., Wednesday, May 11, 1949, in Conference Room No. 6 of the Biltmore Hotel, Los Angeles.

Roll Call:

Present were President Kneeshaw, President-Elect Donald Cass, Councilors Shipman, Ray, M. Laurence Montgomery, MacLean, Lum, Anderson, Cherry, Green, Crane, Henderson, Bailey, Ball, Thompson, Speaker Alesen, Vice-Speaker Charnock, Secretary Garland and Editor Wilbur.

Absent: Mayne E. Pollock and Benjamin Frees (illness).

Present by invitation were Executive Secretary Hunton, Legal Counsel Hassard, Assistant Executive Secretary Wheeler, Rollen Waterson, executive secretary of the Alameda County Medical Association; Kenneth Young, executive secretary of the San Diego County Medical Society; Glenn Gillette, executive secretary of the Fresno County Medical Society; Ned Burman of Public Relations Counsel and Mr. Elwood Bailey, director of the San Diego Convention and Tourist Bureau.

1. *Organization of the Council:*

Vice-Chairman Shipman presided and called for nominations for chairman of the Council. On motion duly made and seconded, Sidney J. Shipman was unanimously elected chairman.

On motion duly made and seconded, H. Gordon MacLean was unanimously elected vice-chairman.

On nomination duly made and seconded, L. Henry Garland was unanimously appointed Secretary-Treasurer.

On nomination duly made and seconded, Dwight L. Wilbur was unanimously appointed Editor.

On nomination duly made and seconded, Peart, Baraty & Hassard were unanimously appointed legal counsel.

2. *Meeting Place for 1950:*

The Council was addressed by Mr. Elwood Bailey, director of the San Diego Convention and Tourist Bureau, who outlined the meeting facilities available in San Diego, answered questions and issued an invitation for the C.M.A. to hold its 1950 Annual Session in San Diego. On motion duly made and seconded, it was voted to hold the 1950 Annual Session in San Diego, starting on April 30, 1950, and continuing for the necessary time.

3. *Study of Alcoholism:*

Discussion was held on the possibilities of publishing the *Study on Alcoholism* prepared by Dr. Cullen Ward Irish and members of his special committee appointed following the 1948 Annual Session. It was pointed out that this study was both complete and valuable and that its findings should be made more generally available.

On motion duly made and seconded, it was voted to investigate the cost of publishing this study and refer the matter to the Executive Committee for consideration.

4. *Manual of Joint Function Measurement for Disability Ratings:*

Dr. Cass called attention to the *Manual of Joint Function Measurement* for disability prepared by Dr. Packard Thurber under authority of the Council and more recently adopted as standard by the Industrial Accident Commission of the State of California. It was regularly moved, seconded and voted that investigation be made of the cost of publishing this manual, either through the Association itself or through an outside publisher, and the matter referred to the Executive Committee.

5. *Blood Bank Commission:*

The Secretary discussed the possibility of loans being made to county medical societies for the establishment of community type blood banks and cited Los Angeles County as one area where such a loan might be productive of advanced procedures and improved public relations. It was regularly moved, seconded and voted that the chairman of the Blood Bank Commission confer without delay with the officers of the Los Angeles County Medical Association and report back to the Council.

It was regularly moved, seconded and voted that authority be granted the Blood Bank Commission to appoint an assistant to the chairman, within financial limits to be determined by the Executive Committee.

6. *Sirens on Ambulances:*

Dr. Wilbur Bailey discussed a proposal to require removal of sirens from privately-operated ambulances and it was regularly moved, seconded and voted to refer this proposal to the Committee on Public Relations.

7. *Special Articles in* CALIFORNIA MEDICINE:

Dr. Wilbur reported that requests had been made for the publication in CALIFORNIA MEDICINE of special articles honoring members who had made outstanding contributions to the profession. There was general discussion and the matter was taken under advisement.

8. *Gorgas Nomination for Hall of Fame:*

A request for approval by the Council of the nomination of Dr. William Crawford Gorgas for inclusion in the Hall of Fame of New York University was presented and it was regularly moved, seconded and voted that the Council approve this nomination.

9. *San Diego County Medical Society:*

The question of providing, for a temporary period, a public relations representative for the San Diego County Medical Society was discussed and it was regularly moved, seconded and voted that the District Councilor and the President-Elect arrange a personal visit with the officers of the San Diego County Medical Society to discuss this matter.

10. *Appointment of Auditing Committee:*

Chairman Shipman announced the appointment of Dr. H. Gordon MacLean as chairman of the Auditing Committee, Drs. Donald Lum and M. Laurence Montgomery as members. The Council approved these appointments.

11. *Public Relations:*

Mr. Burman expressed the need for more resolutions in opposition to a system of national compulsory health insurance by the component county medical societies and it was regularly moved, seconded and voted that the Secretary renew the request to the county societies to take this action, copies of all resolutions to be sent to President Truman, members of Congress, Governor Warren, members of the Legislature and to Whitaker & Baxter, Chicago.

12. *Time and Place of Next Meeting:*

The time and place of the next meeting were left at the call of the chairman.

Adjournment.

SIDNEY J. SHIPMAN, M.D., *Chairman*
L. HENRY GARLAND, M.D., *Secretary*

CORRECTION

The In Memoriam column on page 515 of the June issue of CALIFORNIA MEDICINE contained notice that Dr. Clarence Augustus DePuy had died May 3, 1949. This was in error. It was Dr. E. Spence DePuy, brother of the surviving Dr. DePuy, who died.

NEWS and NOTES

NATIONAL • STATE • COUNTY

SAN FRANCISCO

Establishment of a **cardiovascular research laboratory** by the Stanford University School of Medicine was announced recently. Made possible by contributions from the Bothin Fund and individual philanthropists in San Francisco, the laboratory will be used as an aid in diagnosis of congenital heart disease in patients at Stanford University Hospital and in developing new diagnostic techniques.

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Dr. Dorothy Wells Atkinson, assistant clinical professor in the Department of Medicine at the University of California Medical School, last month was elected president of the American Medical Women's Association for the 1949-50 term.

* * *

Dr. Herbert M. Evans, director of the Institute of Experimental Biology at the University of California, last month was given the highest award of the Association for the study of Internal Secretions for "long-continued outstanding research which has notably advanced knowledge in the field of endocrinology, especially as regards the hormones of the anterior hypophysis."

* * *

A new section on **medical care administration** has been established by the School of Public Health at the University of California. The school is said to be one of five in the United States and the only one in the western states to undertake such a teaching and research program. Dr. E. Richard Weinerman, who was brought to the university as visiting associate professor of medical economics during the current year, will remain in charge of developing the new medical care curriculum.

Steps have been taken, it was reported, to make the new section a useful repository of factual data on medical economics. It plans to organize a library of related material and to conduct research concerning social and economic factors in medical care. The section hopes to serve as a source for consultation in problems of medical care, offering technical aid and other help to interested persons or organizations in the West.

* * *

Dr. Harry C. Warren was elected first vice-president of the American College of Chest Physicians at a meeting of that organization last month in Atlantic City.

SANTA BARBARA

The Western Orthopedic Association will hold a meeting at the Santa Barbara Biltmore Hotel, Santa Barbara, October 19-21, 1949, according to announcement by the association.

SANTA CLARA

Dr. Milton Rose of Palo Alto recently was elected president of the Santa Clara County Mental Hygiene Association, succeeding Curtis Davis, principal of San Jose High School. At the same time it was announced that a grant received from the Rosenberg Foundation in San Francisco will enable the association to extend its work to studies and treatment in child guidance.

SANTA CRUZ

Dr. H. E. Trimble has been appointed medical director of the Santa Cruz County Hospital to succeed Dr. J. J. A. McMullin, resigned. Dr. Trimble formerly served at the medical relief out-patient clinic at San Diego with the Federal Security Agency.

SONOMA

Hartley Peart, legal counselor for the California Medical Association, spoke on "The Professions Today" at a joint meeting of the attorneys, dentists, pharmacists, and physicians of Sonoma County which was held recently under the sponsorship of the **Sonoma County Medical Society.** It was the first such meeting since the beginning of World War II.

GENERAL

Army Medical and dental officers will be given priority of consideration in assignment of quarters, and their families will be permitted to accompany them on tours of foreign duty under a new order by the Department of the Army. This policy, according to official announcement, is the latest step in "a continuing campaign designed to relieve the **critical shortage** of medical and dental officers in the Army by making their careers and living conditions more attractive."

* * *

In a move to provide better professional opportunities for **general practitioners,** a General Practice Branch has been established within the medical service organization of the United States Air Force, according to the office of the Air Surgeon. Richard J. Brightwell, major, M.C., has been appointed acting chief of the branch. Establishment of the branch followed a meeting between representatives of the armed forces and members of the committee on education of the **American Academy of General Practice.**

* * *

A resolution **opposing socialized medicine** was adopted unanimously by the American Council of Christian Churches at its recent convention at Denver. The resolution said, in part:

"Socialized medicine in any form, represents, we believe, a clear violation of the Fourth Amendment of our Constitution which guarantees 'the right of the people to be secure in their persons.'

"The battle against State medicine is not for the doctors alone, but it belongs to all Christian people who cherish their own freedom as well as the physician's."

The Second Annual Meeting of the **American Association of Blood Banks** will convene in Seattle, November 3-5, 1949. A program designed to be of interest to both scientific and administrative personnel of blood banks and hospitals has been arranged, according to a statement accompanying announcement of the meeting. Further information may be had from the office of the secretary, 3301 Junius Street, Dallas 1, Texas.

* * *

Regarding the **status of electroshock therapy**, Dr. William C. Menninger, president of the American Psychiatric Association, and Dr. Nathan K. Rickles, president of the Electro-Shock Research Association, have jointly issued the following statement:

"Electroshock therapy is accepted today as the most effective physical agent in the successful treatment of the majority of the affective psychoses when given by properly qualified psychiatrists.

"It should be stressed that at no time is electroshock advanced as a cure-all, but only as one very effective agent in selected classes of mental illness. It should always be preceded by a complete and thorough psychiatric study of the patient which includes an evaluation of his mental and physical status, his family and his environment, and also be followed with adequate psychosocial study and psychotherapeutic guidance."

* * *

A rapid and accurate method for **reproduction of x-ray photographs** at a distance by wire or radio transmission, so that hospitals in isolated communities may avail themselves of the services of radiologists in larger communities, was described in the May issue of the *American Journal of Roentgenology and Radium Therapy*. The article tells of the daily successful use of roentgenographic facsimile transmission between a hospital and the offices of a roentgenologist 28 miles distant.

* * *

Although working a 60-hour week, the average physician in the United States manages to wedge more than one month of postgraduate study a year into his schedule, according to a survey conducted by Medical Economics. Practicing physicians average an equivalent of 20 days a year reading medical literature, eight days a year studying at medical schools and hospitals, and six days a year attending medical conventions, results of the survey showed.

POSTGRADUATE EDUCATION NOTICES

University of California, Los Angeles

Course: Clinical Neurology in Medical Practice.
Date: July 25 to July 30. Fee: $35.00.
Contact: Office of Medical Extension, University of California, Los Angeles 24, California.

University of California, Medical Center, San Francisco

Course: Medical Aspects of Nuclear Energy.
Date: August 29 through September 3, 1949. Fee: $60.00.
Contact: Stacy R. Mettier, M.D., Medical Extension, University of California Medical Center, San Francisco 22, California.

Course: Physics in Radiation Therapy.
Date: September 6 through September 9, 1949.
Of interest to radiologists, dermatologists, gynecologists, and physicians dealing with radioisotopes.

Course: Otorhinolaryngology, a continuation of 1947 course for specialists.
Date: September 5 through September 9, 1949. Fee: $60.00.

Course: Ophthalmology, a continuation of 1947 and 1948 courses for specialists.
Date: September 12 through 17, 1949. Fee: $60.00.

University Southern California Medical School

Listing of courses not available.
B. O. Raulston, M.D., Dean, 1200 N. State Street, Los Angeles 33, California.

College of Medical Evangelists

Listing of courses not available.
H. M. Walton, M.D., Dean, Graduate School of Medicine, Boyle and Michigan Avenue, Los Angeles 33, California.

Stanford University School of Medicine

The usual fall refresher courses will be given September 19 to 23. Fee: $75.00.
A full announcement of courses will appear in the August issue of CALIFORNIA MEDICINE.
Contact: The Office of the Dean, 2398 Sacramento Street, San Francisco 15, California. Telephone, WEst 1-8000.

BOOK REVIEWS

CHILD PSYCHIATRY. By Leo Kanner, M.D., Associate Professor of Pediatrics and Associate Professor of Psychiatry, The Johns Hopkins University, with prefaces by John C. Whitehorn, M.D., Henry Phipps Professor of Psychiatry, The Johns Hopkins University; Adolf Meyer, M.D., Henry Phipps Professor Emeritus, The Johns Hopkins University, and Edward A. Parks, M.D., Professor Emeritus of Pediatrics, The Johns Hopkins University. Charles C. Thomas, Publisher, Springfield, Illinois, 1948. $8.50.

This is a book which will go far to fill the need many pediatricians feel for a practical reference in the field of child psychiatry. It is a completely rewritten, second edition of a work which appeared in 1935 and was sufficiently well accepted to require five printings up to 1947. The thirteen years which have elapsed since the first printing are years of considerable growth in the field of child psychiatry. This growth, and the maturing effect the interval has had on Dr. Kanner's viewpoint, are both abundantly evident in this second edition.

The clarity of thought, the absence of specialized verbiage, and the general readability which characterize Dr. Kanner's writing, all add to the pleasure of using this text. His point of view is broad and "multidimensional"—and does not confine itself to a single school of thought.

Problems are well illustrated by examples taken from Dr. Kanner's clinical files, and references are abundant and up-to-date. The organization of the book and its index provide ready reference to everyday problems in child behavior.

More serious psychiatric disturbances are also discussed, but it is especially in the area of common behavior disturbances that the book is designed to offer the greatest help. It serves this purpose very well indeed.

* * *

MAGIC IN A BOTTLE. By Milton Silverman, Ph.D., Science Editor, San Francisco Chronicle, Macmillan Co., 1948. $3.50.

To write a reasonably accurate historical account of the development and use of many of the drugs which form an important part of the therapeutic armamentarium of the modern physician is a worthwhile accomplishment. To do so in a manner which is entertaining to the scientist and the medical practitioner, as well as to the layman, is a demonstration of an ability which is not frequently found. The author has done just that. Even though he has not attempted to produce an exhaustive account of this topic in this second edition of his book, he brings the subject matter up to date. Even though it is written more as a narrative than as a scientific thesis, it contains information which can be profitable to those who are interested in medical history and in the modern practice of medicine. The descriptions of the personalities involved are of special interest. The book is good reading.

* * *

TEXTBOOK FOR ALMONERS. By Dorothy Manchee, Almoner, St. Mary's Hospital, London, and Foreword by Sir Alfred B. Howitt, C.V.O., M.D., President, Institute of Almoners (Chairman, Institute of Hospital Almoners 1931-1945), The Williams and Wilkins Co., Baltimore, Md., 1947. $7.50.

An almoner has been defined as: "An official distributor of the alms of another; a functionary in a religious house or in a hospital, such as a chaplain, etc."

This book deals with the origin and growth of the almoner's service, social legislation, the economic and social aspects of disease and the almoner's place in a rehabilitation scheme. At first glance the American reader might feel that the text would only be of interest to hospital administrators and social service workers. However, since it represents the thinking of some distinguished medical sociologists in a country now thoroughly Beveridge-ized, our children may rebuke us for not taking off a few hours to peruse its contents.

St. Mary's Hospital in London has been visited by many physicians from California. The author has been almoner to that hospital for many years. The book was published before the National Health Act went into force but does contain many references to the adumbrating legislation.

* * *

1948 YEARBOOK OF OBSTETRICS AND GYNECOLOGY. Edited by J. P. Greenhill, B.S., M.D., F.A.C.S. The Yearbook Publishers, Inc., Chicago, Ill., 1949. $4.50.

The 1948 Yearbook of Obstetrics and Gynecology edited by J. P. Greenhill, M.D., of Chicago, like most former editions by this author, is a complete survey of the worthwhile literature of this field of medicine of the entire world. The Yearbook, with the crisp, honest comments of the editor, makes for pleasant as well as beneficial reading.

The Section on Obstetrics gives an encouraging report on the reduction of maternal and fetal mortality. The subject of the Rh factor is well covered, as well as the problem of rubella complicating the early months of pregnancy. Two new analgesics are presented—dolophine and inhalation trilene. The cesarean problem is well presented. The question of whether repeat sections should always be done is discussed by Greenhill. He feels that in most instances the danger of rupture is too great to allow these patients to go into labor.

In the section on Gynecology there are several articles reviewing the importance and value of hysterosalpingography for conditions other than sterility. Total hysterectomy continues to be a much discussed problem and the editor's comment on the articles by Pfaneuf and Jones is particularly timely, that is, "despite the advisability of total operations, men with limited experience in pelvic surgery are wise to perform supravaginal hysterectomies." Urinary incontinence and prolapse of the vaginal vault and the cervical stump are carefully reviewed.

The section on menstruation and endocrinology will save hours of useless reading because all of the worthwhile articles are summarized and Dr. Greenhill has crystallized the thinking of most gynecologists in a very satisfactory manner.

As usual, everyone doing Obstetrics and Gynecology should have this valuable epitome of the literature of 1948.

* * *

FAILURES IN PSYCHIATRIC TREATMENT. Edited by Paul H. Hoch, M.D., New York State Psychiatric Institute, N. Y. C.; Principal Research Scientist (Psychiatry), New York State Psychiatric Institute; Associate in Psychiatry, Columbia University College of Physicians and Surgeons, N. Y. C.—The Proceedings of the Thirty-seventh Annual Meeting of the American Psychopathological Association, held in New York City, June 1947. Grune and Stratton, New York, 1948. $4.50.

This book contains the procedures of the 37th annual meeting of the American Psychopathological Association held in June, 1947. It is of special interest because unlike most reports it does not discuss cures and ways in which success was achieved. Instead it discusses the failures and the reasons for failure. This is a very interesting and valuable approach. In most books, emphasis has been mainly on doing certain things which will achieve cure. Causes of failure have been touched on many times but there are very few

works which set down and analyze the causes of failure. The book therefore is to be highly recommended to everyone interested in psychiatric treatment.

The different chapters represent papers presented by the authors at the meeting of the American Psychopathological Association. There is considerable difference of approach so that some chapters contain a general discussion of principles whereas other chapters take up more individual cases and show why failures occurred in particular cases.

The chapters roam all the way from Chapter 2 which is "Failures with Psychoanalytic Therapy"; Chapter 6, "Failures in the Psychotherapy of Children"; Chapter 7, "Failures in Psychosomatic Case Treatments"; Chapter 8, "Group Psychotherapy"; Chapter 10, "Failures with Insulin Shock Therapy"; Chapter 11, "Failures with Electric Shock Therapy"; and passing on to such subjects as prefrontal lobotomy, neurosyphilis, epilepsy, and even social case work. The different chapters vary somewhat in their value, but all of them are well written and are good discussions of the subject.

* * *

HANDBOOK OF MATERIA MEDICA, TOXICOLOGY, AND PHARMACOLOGY, For Students and Practitioners of Medicine. By Forrest Ramon Davison, B.A., M.Sc., Ph.D., M.B., Consultant and Toxicologist, Minneapolis, Minnesota. Fourth Edition. The C. V. Mosby Company, St. Louis, 1949. $8.50.

This handbook, originally published in 1940, has been revised, in part, to meet criticisms levelled against earlier editions. The title indicates the fact that the text is "dated," and in Part I, perhaps, the subject matter is of greater interest to the pharmacist than to the practicing physician. Part II is, in essence, a facsimile after the Cushny style, with respect to classification of subject matter. Unfortunately, critical judgment of old, as well as new drugs, of help to the physician, is lacking. For this reason, the handbook is really a compendium of practically all agents which at one time or another have been considered useful. Certainly, many of the drugs given space in the text are superseded today by others of proven value. The size and price of the book are not justified on the basis of the subject matter selected and the manner of its presentation.

* * *

ESSENTIALS OF PUBLIC HEALTH. By William P. Shepard, B.S., M.D., M.A., with the collaboration of Charles Edward Smith, M.D., D.P.H.; Rodney Rau Beard, M.D., M.P.H.; Leon Benedict Reynolds, A.B., Sc.D., with a foreword by Ray Lyman Wilbur, M.D., LL.D., Sc.D., Chancellor, Stanford University; Ex-Secretary of the Interior; formerly President of Stanford University, J. P. Lippincott Company, Philadelphia, 1948. $5.00.

This book of 600 pages is conveniently arranged in compact handbook form and liberally indexed and documented.

Intended primarily for the general practitioner of medicine, it should nevertheless serve equally for the medical student and also should find a place as a useful reference work for the professional in public health and preventive medicine. Because it covers extensive subject matter condensation has been necessary and with it comes the possible risk of misinterpretation of detail particularly where such detail deals with difficult or controversial subject matter. However, each chapter is thoroughly documented with bibliographical references that will aid the student of any particular subject discussed in pursuing his reading further.

The book starts with a splendid background orientation in the general objectives and philosophies of traditional public health function and the administrative structure usually encountered in public health activities. Unusual in a book of this kind is the authors' treatment of administrative responsibility in which they present a well considered picture of the role, both immediate and future, of the various official and voluntary agencies that are active in the health field. The concise manner in which this has been done in the presentation of each major area of public health activity makes this information particularly accessible at the points in the book where it is most useful.

Particularly useful to busy practitioners are a number of innovations such as the quick reference tables concerning many elusive facts such as communicable diseases regulations in Chapter IV, the submission of laboratory specimens and their interpretation in Chapter V, and the long list of diseases responsive to immunization of one kind or another in Chapter VI.

The authors' frequent references to the evaluation of specific public health activities based on the interpretation of the survey schedules of the American Public Health Association are interesting but subject to some misinterpretation. This use of such health practice indices can be considered valid only in relation to the forward motion of the particular service in question. For example, the high percentage of obstetric cases that must be hospitalized to be classified as "good" in this analytical array of services from good, fair, to poor, represents a considerable level of perfection. On the other hand, the assignment of 12 per cent as the community level considered "good" for the vaccination against smallpox of infants under one year, though it may compare favorably with the rate for the nation as a whole, can, by no stretch of the imagination, be considered really good in terms of preventive medical practice. Care, therefore, should be used in applying these somewhat arbitrary grade classifications to public health practice in a given community.

It is particularly pleasant to find the concluding chapter dealing with statistics as applied in the determination and measurement of morbidity and mortality data. This section is planned for the orientation of the general practitioner to biostatistical methods in order to enable him better to evaluate these procedures.

In short, this book will be a most useful addition to the library of the practicing physician and the student of preventive medicine and public health.

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A METHOD OF ANATOMY, DESCRIPTIVE AND DEDUCTIVE. By J. C. Boileau Grant, M.C., M.B., Ch.B., F.R.C.S. (Edin.), Professor of Anatomy, University of Toronto, Fourth Edition, The Williams and Wilkins Co., Baltimore, Md., 1948. $7.00.

This is an excellent work on anatomy written primarily for the physician or surgeon seeking useful information in the field which can be immediately applied to clinical or surgical problems. It presents anatomy not as a mere conglomeration of impractical facts which must be memorized and retained, but as a functional integration of anatomical facts correlated admirably with embryology, function, and clinical interrelationships. The human body is considered by regions, and the key to the region is the predominant clinical feature or surgical feature of the area. The development of the text centers around the clinical or surgical implications, and the utility of the anatomy is immediately grasped from this method of exposition. The text is well illustrated with line drawings and diagrams which clearly depict the interrelationships of the various structures in the area.

This is a particularly readable and handy reference book for the surgeon. It is not so cumbersome or detailed as Callendar's text and yet presents anatomy in a much more practical manner. It surpasses McGregor's book in the same field by its ease of presentation and superior drawings. This book makes anatomy rational, direct, and applicable to the problems of medicine and surgery. The reviewer recommends it wholeheartedly.

SYMPTOMS IN DIAGNOSIS. By Jonathan Campbell Meakins, C.B.E., M.D., D.Sc., LL.D., formerly Professor of Medicine and Director of the Department of Medicine, McGill University. Illustrated. The Williams and Wilkins Company, Baltimore, 1948. $7.50.

This is a concise, usable book written from the clinical point of view. It is not encyclopedic, but can serve well as a reference book because of its practical character. It emphasizes the too frequently overlooked fact that symptomatology may be of greater importance in the investigation of the average case than physical examination or laboratory findings.

There are inevitable drawbacks to a text limited to the extent that this one is: Interpretations of certain symptoms are developed to the exclusion of others equally important; elaborations of the etiology or treatment of one cause of a symptom leave room for only brief mention of other causes. On the whole, Dr. Meakins has shown good judgment in his choice of subjects to be emphasized. His discussions are good. His style, while occasionally oracular, is conversational and interesting. It is surprising and regrettable that it is also frequently and confusingly ungrammatical. The number of misspelled words seems unusually high.

There are four chapters—about two-fifths of the book—which have been written by collaborators. The work of these authors is written in less interesting but more grammatical fashion.

In spite of the criticism, this is a much better than average book. It is well indexed; the information included is medically accurate; the illustrations are well selected. It can be recommended for the reference shelf of the student or intern as well as for the office of the practitioner.

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OFFICE MANUAL FOR THE MEDICAL SECRETARY. By Evangeline Markwick, Ph.D., Instructor in Secretarial and Medical Secretarial Studies, Green Mt. Jr. College, Poultney, Vt.; Agnes Erickson, M.A., Instructor in Secretarial and Medical Secretarial Studies, Colby Jr. College, New London, N. H.; M. Herbert Freeman, Ph.D., Head of Business Education Dept., New Jersey State Teachers College, Paterson, N. J. Gregg Publishing Co., New York, N. Y., 1947. $2.40.

This book offers a practical solution for many problems of the medical secretary and the girl who is training for this work.

The duties of the clerk, stenographer, receptionist, and laboratory assistant are comprehensively enumerated. The Hippocratic Oath, and the Code of Medical Ethics are given. The necessary financial activities and legal responsibilities are listed. Helpful suggestions are offered for office housekeeping, filing, accounting, editorial assisting, and correspondence.

Four reference sections include: Specialties and Journals, Report on Findings of Research on Duties of Medical Secretaries, Correct Usage for the Medical Secretary, Medical Ethics.

The style of writing of the book is interesting, and the subject matter is comprehensive enough for the book to be used for general reference. In addition, a bibliography is given for technical references.

The information given is of great value because it offers specific, real facts. The authors also trace the development of accepted methods and techniques.

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PRIMARY ANATOMY. By H. A. Cates, M.B., Professor of Anatomy, University of Toronto. The Williams and Wilkins Company, Baltimore, Maryland, 1948. $6.00.

This is a very short book of fundamental anatomy written primarily for nursing students or students of elementary anatomy in the colleges. It would be of little or no value to a physician or practicing surgeon. This text was written specifically for the students in the ancillary fields of medicine, notably nursing, physiotherapy, and physical education, and presents in a clear and concise fashion anatomy at this level. In this regard it is an excellent work, but would not appeal to physicians because of its utmost simplicity and lack of detailed information essential for clinical utility.

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AN INTRODUCTION TO CARDIOLOGY. By Geoffrey Bourne, M.D., Physician, and Physician in Charge of the Cardiological Department, St. Bartholomew's Hospital. The Williams and Wilkins Company, Baltimore, Md., 1949. $4.50.

This textbook of cardiology has several excellent chapters which reflect an extensive clinical experience. There are several opinions expressed, however, with which many American physicians might disagree. The half page of emphasis placed upon the technique of using Southey's tubes and acupuncture in the elimination of edema, in relation to the several lines given to the use of a low sodium diet, would seem out of proportion to their importance. The acceptance of total thyroidectomy for the treatment of chronic congestive failure and angina pectoris is at variance with the reviewer's experience. Most American cardiologists have discarded this procedure. Several suggestions in treatment are unacceptable. Digitalis is advocated for ventricular paroxysmal tachycardia, a procedure which is generally regarded not only as not beneficial, but usually as hazardous.

There is a delightful discussion, however, upon the clinical forms of angina pectoris and its mimicry by innocent left submammary pain in Chapters XXIX and XXX. This is quite in keeping with the peculiar ability which the good English physician seems to possess in the lucid description of disease.

This book is recommended more because of its individually interesting chapters than because of its value as an up-to-date manual of cardiology for the practicing physician.

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CARE OF THE SURGICAL PATIENT — Including Pathologic Physiology and Principles of Diagnosis and Treatment. By Jacob Fine, M.D., Surgeon-in-Chief, Beth Israel Hospital, Professor of Surgery, Harvard Medical School. W. B. Saunders Company, Philadelphia, 1949. 8.00.

The book, as its preface indicates, is intended to serve as a ready guide for the over-all care of the surgical patient.

The author has elected to divide the contents into six chapters. The first chapter, entitled "General Considerations," includes useful hints in surgical diagnosis, fluid and electrolyte balance, nutrition, hemorrhage, shock and surgical infections. The second chapter: "Regional and Special Surgery," covers surgical care of specific areas. This chapter covers not only every phase of abdominal and chest surgery but also important points in the care of neurosurgical, orthopedic and otolaryngological patients. The third chapter: "Endocrine Disease and Hormone Therapy," contains excellent coverage of each gland of internal secretion. The fourth chapter: "Coincidental Medical Illnesses in Surgical Patients," covers the anemias, cardiac disease, diabetes, skin disorders and renal disorders. The fifth chapter is devoted to clinical laboratory methods and the last chapter on "General Preoperative and Postoperative Care." There are 40 illustrations.

This book is not intended to cover surgical technique. Reference to technique is made whenever it reflects upon postoperative care. The book is written in an informal, easily understandable manner. It can be well recommended not only for use by the surgeons and surgical residents, but also by the general practitioner and the internist with whom, after all, the burden of pre- and postoperative care is shared by the surgeon.